The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.umr.com or by calling 1-800-221-6346. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.umr.com or call 1-800-221-6346 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$350 person / $700 family HSHS Select (Tier 1) $700 person / $1,400 family HSHS Extended (Tier 2) $2,100 person / $4,200 family UHC Choice Plus (Tier 3) & Non-Network (Tier 4)	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$3,000 person / $6,000 family HSHS Select (Tier 1) & HSHS Extended (Tier 2) $6,000 person / $12,000 family UHC Choice Plus (Tier 3) & Non-Network (Tier 4)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-221-6346 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge; Deductible Waived	20% Coinsurance; Deductible Waived	40% Coinsurance	Not covered	None
	Specialist visit	No charge; Deductible Waived	20% Coinsurance	40% Coinsurance	Not covered	None
	Preventive care/ screening/ immunization	No charge; Deductible Waived	No charge; Deductible Waived	No charge; Deductible Waived	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge; Deductible Waived	20% Coinsurance	40% Coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	20% Coinsurance	40% Coinsurance	Not covered	None

Common Medical Event	Services You May Need	Your Cost If You Use a Network Pharmacy	Your Cost If You Use a Non-Network Pharmacy	Limitations, Exceptions & Other Important Information
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.optumrx.com	Generic drugs (Tier 1)	HSHS: 10% Coinsurance All Others: 20% Coinsurance	Not covered	HSHS Select deductible and HSHS Select out-of-pocket limit applies. Retail – 30 day supply Mail – 90 day supply If you choose to receive a brand name medication when a direct generic equivalent is available, you must pay the difference in price between the brand drug and its generic equivalent in addition to the applicable copay and generic coinsurance. Maintenance medications at HSHS, mail order or Walgreens required for coverage after the second fill at a retail pharmacy. After the initial fill, specialty medications must be filled through OptumRx or HSHS to be covered. Prior authorization may be required.
	Preferred brand drugs (Tier 2)	HSHS: 20% Coinsurance All Others: 30% Coinsurance	Not covered	
	Non-preferred brand drugs (Tier 3)	HSHS: 20% Coinsurance after $15 copay All Others: 30% Coinsurance after $15 copay HSHS Mail Order: 20% Coinsurance after $45 copay All Others Mail Order: 30% Coinsurance after $45 copay	Not covered	
	Specialty drugs (Tier 4)	HSHS: 20% Coinsurance All Others: 30% Coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	20% Coinsurance	40% Coinsurance	Not covered	None
If you have outpatient surgery	Physician/surgeon fees	10% Coinsurance	20% Coinsurance	40% Coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	Facility - $100 Copay per visit; 10% Coinsurance; Deductible Waived Physician – 10% Coinsurance	Facility - $100 Copay per visit; 20% Coinsurance; Deductible Waived Physician – 20% Coinsurance	Facility - $100 Copay per visit; 20% Coinsurance; Deductible Waived Physician – 20% Coinsurance	Facility - $100 Copay per visit; 20% Coinsurance; Deductible Waived Physician – 20% Coinsurance	Tier 2 deductible applies to Tiers 3 & 4 physician benefits; Copay may be waived if admitted
	Emergency medical transportation	10% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance	Tier 2 deductible applies to Tiers 3 & 4 benefits; Preauthorization is required for Non-emergent Air ambulance. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Urgent care	10% Coinsurance	20% Coinsurance	40% Coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	20% Coinsurance	40% Coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Physician/surgeon fees	10% Coinsurance	20% Coinsurance	40% Coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	No charge; Deductible Waived Office visits; 10% Coinsurance other outpatient services	20% Coinsurance; Deductible Waived Office visits; 20% Coinsurance other outpatient services	40% Coinsurance	Not covered	Preauthorization is required for Partial hospitalization. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Inpatient services	10% Coinsurance	20% Coinsurance	40% Coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
If you are pregnant	Office visits	No charge; Deductible Waived	No charge; Deductible Waived	No charge; Deductible Waived	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% Coinsurance	20% Coinsurance	40% Coinsurance	Not covered	
	Childbirth/delivery facility services	10% Coinsurance	20% Coinsurance	40% Coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay				What You Will Pay
		Tier 1	Tier 2	Tier 3	Tier 4	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	20% Coinsurance	40% Coinsurance	Not covered	120 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Rehabilitation services	10% Coinsurance; Deductible Waived	20% Coinsurance	40% Coinsurance	Not covered	None
	Habilitation services	10% Coinsurance; Deductible Waived	20% Coinsurance	40% Coinsurance	Not covered	Habilitation services for Learning Disabilities are not covered.
	Skilled nursing care	10% Coinsurance	20% Coinsurance	40% Coinsurance	Not covered	180 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Durable medical equipment	10% Coinsurance	20% Coinsurance	20% Coinsurance	Not covered	Tier 2 deductible applies to Tier 3 benefits; Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases. If you don't get preauthorization, benefits could be reduced by $250 per occurrence.
	Hospice service	10% Coinsurance	20% Coinsurance	40% Coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (Tiers 1, 2, & 3 only)
- Bariatric surgery (Tier 1 only)
- Chiropractic care (Tiers 1, 2, & 3 only)
- Hearing aids (Tiers 1, 2, & 3 only)
- Private-duty nursing (Outpatient care Tiers 1, 2, & 3 only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan Provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan Meet the Minimum Value Standard? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$350**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,610**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$350**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$350
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,170**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$350**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$350
Copayments	$100
Coinsurance	$250
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.