UMR: GREEN BAY AREA PUBLIC SCHOOLS: 7670-00-411738 004

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 1-800-207-3172. 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 1-800-207-3172 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500 person / Unlimited family	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?	$2,500 person / $12,700 family In-network $2,500 person / Unlimited family Out-of-network	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 1-800-207-3172 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
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copay per visit; 20% Coinsurance	$25 Copay per visit; 40% Coinsurance	None
	Specialist visit	$40 Copay per visit; 20% Coinsurance	$40 Copay per visit; 40% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	$25 Copay per exam; 40% Coinsurance	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)	20% Coinsurance	40% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	None
If you need drugs to treat your illness or condition. Check prescription drug coverage, costs, find a pharmacy and more from www.caremark.com, the CVS/caremark smart phone app or call toll-free at 1-866-818-6911. General information is also available from the CVS Caremark YouTube Channel CVS/specialty is the plans preferred provider of specialty drugs. Call 1-800-237-2767 or visit www.cvsspecialty.com Call PrudentRx at 1-800-578-4403 to enroll.	Preventive Drugs (Affordable Care Act) Covered diabetic supplies	One month supply: $0 Three month supply: $0	One month supply: $0 Three month supply: $0	All products may not be covered. Prior authorization, age parameters, quantity limitations or other utilization management may apply. After 2 refills (initial fill plus two refills so 3 fills total) of maintenance medications, a 90 day (three month) supply is required from Caremark Mail Service or a retail CVS, Costco or Kroger pharmacy (may be subject to change). If you or your doctor request a brand name drug when a generic is available, you may pay the applicable brand copay plus the difference in cost between the brand and generic drug. This cost difference is not applied to the out-of pocket maximum. If you use a non-participating pharmacy, you will need to pay for the prescription up front and then submit claim reimbursement form with a receipt to CVS/caremark for reimbursement. Reimbursement for covered prescription products will be based on the contract rate minus any applicable cost shares shown under Out-of-Network
	Generics	One month supply: $15 Three month supply: $30	One month supply: $15 Three month supply: $30	
	Preferred brands	One month supply: $30 Three month supply: $75	One month supply: $30 Three month supply: $75	
	Non-preferred brands	One month supply: $50 Three month supply: $125	One month supply: $50 Three month supply: $125	
	Compounds Specialty	30% coinsurance 30% coinsurance or $0 with PrudentRx enrollment	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None
If you need immediate medical attention	Emergency room care	$250 Copay per visit; 20% Coinsurance	$250 Copay per visit; 20% Coinsurance	In-network deductible applies to Out-of-network benefits; Copay may be waived if admitted
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits
	Urgent care	$75 Copay per visit; 20% Coinsurance	$75 Copay per visit; 20% Coinsurance	In-network deductible applies to Out-of-network benefits
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay per visit; 20% Coinsurance office visit; 20% Coinsurance other outpatient services	$25 Copay per visit; 40% Coinsurance office visit; 40% Coinsurance other outpatient services	Preauthorization is required for Partial hospitalization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Inpatient services	20% Coinsurance	40% Coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No charge; Deductible Waived	40% Coinsurance	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	20% Coinsurance	40% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	80 Maximum visits per plan year; Preauthorization is required.
	Rehabilitation services	$25 Copay per visit; 20% Coinsurance	$25 Copay per visit; 40% Coinsurance	None
	Habilitation services	$25 Copay per visit; 20% Coinsurance	$25 Copay per visit; 40% Coinsurance	Habilitation services for Learning Disabilities are not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Skilled nursing care	20% Coinsurance	40% Coinsurance	100 Maximum days per plan year; Preauthorization is required.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases.
	Hospice service	20% Coinsurance	40% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	$25 Copay per exam; 20% Coinsurance	$25 Copay per exam; 40% Coinsurance	1 Maximum exam per plan year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	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.)

- Acupuncture
- Dental care (adult)
- Infertility treatment
- Long-term care
- 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.)

- Bariatric surgery
- Chiropractic care
- Cosmetic surgery - if medically necessary
- Hearing aids - to age 18; 1 per ear every 3 years
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Outpatient care)
- Routine eye care (adult) – 1 exam per plan year

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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-207-3172.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-207-3172.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-207-3172.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-800-207-3172.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-207-3172.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-207-3172.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-207-3172.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-207-3172.

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

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	$500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,570**

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

The plan's overall deductible	$500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$500
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$5,100**

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

The plan's overall deductible	$500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$500
Copayments	$500
Coinsurance	$500
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,510**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-207-3172.