




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, including a copy of your plan's summary plan description, go to [www.speiasc.org](http://www.speiasc.org). 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.cciio.cms.gov](http://www.cciio.cms.gov).

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<b>\$750</b> person / <b>\$1,500</b> family for each network and non-network providers.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <b>Preventive care services</b> , Prescription Drugs, Allergy testing, Durable Medical Equipment and certain Transplants are covered before you meet your deductible, if provided by a Network Provider.	This plan covers some items and services even if you haven't yet met the annual <b>deductible</b> amount, but a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this plan covers certain <b>preventive services</b> without cost-sharing and before you meet your deductible. See a list of covered <b>preventive services</b> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a>
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>What is the out-of-pocket limit for this plan?</b>	Network Medical: <b>\$1,500</b> person / <b>\$3,000</b> family; Non-Network Medical <b>\$3,000</b> person / <b>\$6,000</b> family. Prescription Out-of-Pocket Limit: <b>\$5,650</b> person / <b>\$11,300</b> family	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, and health care this <b>plan</b> doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.umar.com">www.umar.com</a> or call 1-800-535-6373 for help in locating a network provider.	This <b>plan</b> uses a network provider. You will pay less if you use a provider in the <b>plan's</b> network. You will pay more if you use an <b>out-of-network provider</b> , and you might receive a bill from the <b>out-of-network provider</b> for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an <b>out-of-network</b> provider for some services (such as lab work). For <b>out-of-network</b> charges, the Plan's Allowed Amount is set at the lesser of the amount billed or 175% of Medicare Like Rates. Check with your provider before you get services.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No, you don't need a referral to see a <u>specialist</u>	You can see the <u>specialist</u> you choose without permission from this plan.
--	--	---

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u> ; No charge for Teladoc telehealth visits	40% <u>coinsurance</u>	Acupuncture must be provided by chiropractor of licensed Acupuncturist; limited to treatment for chronic pain and nausea associated with surgery, chemotherapy, or pregnancy. Maximum of 26 visits per year for chiropractic and acupuncture care.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	For a pregnancy, two ultrasounds are covered 100% as preventive care; additional ultrasounds may be subject to coinsurance. Includes one diagnostic breast cancer mammogram, if medically necessary, per year at no charge (in addition to one breast cancer screening mammogram per year); additional breast cancer mammograms are subject to <u>coinsurance</u> .

\* For more information about limitations and exceptions, see the plan or policy document at [www.speiasc.org](http://www.speiasc.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Formulary Drugs	Greater of \$8 (retail 31-day) <b>copay</b> or 20%. Or, \$16 (mail order/ retail 90-day) <b>copay</b> or 20%	Greater of \$8 <b>copay</b> or 20% plus difference between negotiated rate and charge per drug (retail)	Covers up to a 31-day supply (retail); 31-90- day supply (mail order/retail). <b>Copay</b> capped at \$100 (retail/31 day) / \$200 (mail order/retail 90-day) per drug. No coverage for non-network mail-order prescriptions. May be subject to Prior Authorization, Step Therapy and Quantity Limits. Dispensed through the <a href="http://www.caremark.com">www.caremark.com</a> pharmacy network.
	Non-Formulary Drugs	No coverage	No coverage	-----none-----
	Prescribed PPI/NSAH Over-The-Counter (OTC Drugs)	No charge	No coverage	-----none-----
	<u>Specialty drugs</u>	Greater of \$8 (retail 31-day) <b>copay</b> or 20%. Or, \$16 (mail order/ retail 90-day) <b>copay</b> or 20%	No coverage	<b>Copay</b> capped at \$100 (retail/31 day) / \$200 (mail/retail 90-day order) per drug. Not subject to <b>out-of-pocket limit</b> . Certain specialty drugs are subject to the PrudentRx Specialty Drug Copay Program.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <b>coinsurance</b>	40% <b>coinsurance</b>	-----none-----
	Physician/surgeon fees	20% <b>coinsurance</b>	40% <b>coinsurance</b>	-----none-----
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$100 <b>copay</b> per visit & 20% <b>coinsurance</b>	\$100 <b>copay</b> per visit & 20% <b>coinsurance</b>	<b>Copay</b> is not charged if admitted.
	<u>Emergency medical transportation</u>	20% <b>coinsurance</b>	20% <b>coinsurance</b>	Air ambulance subject to a \$25,000 maximum benefit.
	<u>Urgent care</u>	20% <b>coinsurance</b>	40% <b>coinsurance</b> ; No charge for Teladoc telehealth visits	Teladoc telehealth services available at \$0 copayment at <a href="http://www.teladoc.com">www.teladoc.com</a>
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Private rooms covered only if medically necessary.
	Physician/surgeon fees	20% <b>coinsurance</b>	40% <b>coinsurance</b>	-----none-----
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Services must be provided by agencies meeting certain qualifications. See <b>plan</b> for additional requirements and exceptions.
	Inpatient services	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Services must be provided by agencies meeting certain qualifications. See <b>plan</b> for additional requirements and exceptions.
<b>If you are pregnant</b>	Office visits	No charge	40% <b>coinsurance</b>	Cost sharing does not apply to certain preventive services. Two ultrasounds are covered 100% as <b>preventive care</b> ; additional ultrasounds are subject to <b>coinsurance</b> .

\* For more information about limitations and exceptions, see the plan or policy document at [www.speiasc.org](http://www.speiasc.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Depending on the type of services or lab work, <b>coinsurance</b> may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	20% <b>coinsurance</b>	40% <b>coinsurance</b>	-----none-----
	Childbirth/delivery facility services	20% <b>coinsurance</b>	40% <b>coinsurance</b>	-----none-----
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Prior authorization required. Services must be provided by a Medicare-certified home health agency. See <b>plan</b> for additional requirements and exceptions.
	<u>Rehabilitation services</u>	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Excludes activities of daily living. Prior authorization required after 25 visits.
	<u>Habilitation services</u>	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Excludes activities of daily living. Prior authorization required after 25 visits.
	<u>Skilled nursing care</u>	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Prior authorization required. Confinement must begin within 30 days of discharge from hospital for same or related illness.
	<u>Durable medical equipment</u>	20% <b>coinsurance</b> , no <b>deductible</b>	20% <b>coinsurance</b> , no <b>deductible</b>	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<u>Hospice services</u>	20% <b>coinsurance</b>	No coverage	
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Plan provides \$200 allowance per year, otherwise no coverage.	Limited to one exam per year. Benefit provided through Vision Service Plan, <a href="http://www.vsp.com">www.vsp.com</a> . or 800-877-7195.
	Children's glasses	No charge for lenses, \$150 allowance or frames of choice, or \$170 allowance for featured frame brands, or \$80 allowance for Costco frames.	\$200 allowance per year, otherwise no coverage.	20% off the amount over allowance for frames. Benefit provided through Vision Service Plan, <a href="http://www.vsp.com">www.vsp.com</a> or 800-877-7195.
	Children's dental check-up	No Charge	Coverage is capped at In-network Allowed Amount, so there may be a balance bill.	Go to <a href="http://www.deltadentalmn.org">www.deltadentalmn.org</a> for a list of participating providers.

\* For more information about limitations and exceptions, see the plan or policy document at [www.speiasc.org](http://www.speiasc.org).

## Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Infertility treatment</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Non-Formulary Drugs</li><li>• Private-duty nursing</li></ul>	<ul style="list-style-type: none"><li>• Retail Weight loss programs</li></ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"><li>• Acupuncture (limited to treatment for chronic pain And nausea associated with surgery, chemotherapy or pregnancy)</li><li>• Bariatric surgery</li><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Dental care (Adult) (through Dental Care Benefits Plan)</li><li>• Hearing aids</li><li>• Wigs for chemotherapy patients (lifetime max of \$1400)</li></ul>	<ul style="list-style-type: none"><li>• Most coverage provided outside the United States.</li><li>• Routine eye care (Adult) (through Vision Service Plan)</li></ul>

**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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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](http://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. For more information about your rights, this notice, or assistance, contact: 1-651-776-4239 or [www.speiacs.org](http://www.speiacs.org).

### Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet the Minimum Value Standards? **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 1-866-811-6086.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-811-6086.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-811-6086.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-811-6086.

Hmong (Hmong): Kev pab nyob rau hauv Hmong, thov hu rau: 1-866-811-6086.

Somali (Soomaali): Wixii caawimaad ah ee Soomaaliya, fadlan wac: 1-866-811-6086.

—————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 **\$750**
- Specialist [cost sharing] **20%**
- Hospital (facility) [cost sharing] **20%**
- Other [cost sharing] **20%**

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

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,060</b>

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

- The plan's overall deductible **\$750**
- Specialist [cost sharing] **20%**
- Hospital (facility) [cost sharing] **20%**
- Other [cost sharing] **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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$700
Coinsurance	\$270
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Joe would pay is</b>	<b>\$1,720</b>

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

- The plan's overall deductible **\$750**
- Specialist [cost sharing] **20%**
- Hospital (facility) [cost sharing] **20%**
- Other [cost sharing] **20%**

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

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$100
Coinsurance	\$390
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Mia would pay is</b>	<b>\$1,240</b>

Note: The "Peg is Having a Baby" Example assumes mother and child each have separate Medical/Pharmacy cost-sharing and OOP limits. The Example assumes Peg gave birth to one child with limited pharmacy. The Diabetes Example assumes that Joe is receiving some medical care, but mostly pharmacy benefits, implicating medical OOP and pharmacy OOP. The Simple Fracture Example assumes only medical care occurred with no pharmacy, so the care is capped by the medical OOP. THESE ARE EXAMPLES ONLY; YOUR FACT SITUATION MAY BE DIFFERENT.

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