UMR - YOUNG LIFE: 90/70 Stateside -7670-00-410569 001 **Coverage for:** Individual & Family | **Plan Type:** PPO

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, [insert contact information]. 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.healthcare.gov/sbc-glossary.com or call HR/Benefits at 1-719-381-1950 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200/Individual or $400/family	Generally, you must pay all of 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 and accident-related 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 a deductible for specific services.
What is the out-of-pocket limit for this plan?	$3,000 individual / $5,000 family	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?	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 1-877-239-4575 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.	This plan does not require a referral to see a specialist. A referral is only required for massage therapy.

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 provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance for office visit and other outpatient services	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	Preauthorization is not required.
	Preventive care/screening/ immunization	No charge	30% coinsurance	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 plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	
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)*	$7 copay/prescription (retail & mail order)	$7 copay/prescription (retail & mail order); plus amounts over plan allowance	Covers up to a 90-day supply for retail and mail order. One copay is waived for a 90-day mail order supply. Contraceptives characterized as Plan B or "morning after" drugs or any other kind of abortifacient are not covered.
	Preferred brand drugs (Tier 2)*	$25 copay/prescription (retail & mail order)	$25 copay/prescription, plus amounts over plan allowance	
	Non-preferred brand drugs* (Tier 3)	$50 copay/prescription (retail & mail order)	$50 copay/prescription, plus amounts over plan allowance	
	Specialty drugs (Tier 4)*	$100 copay/prescription	$100 copay/prescription; plus amounts over plan allowance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Preauthorization is not required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Anesthesia and other ancillary fees will be paid in accordance with the hospital's network status.
If you need immediate medical attention	Emergency room care	10% coinsurance	30% coinsurance	None.
	Emergency medical transportation	10% coinsurance	30% coinsurance	
	Urgent care	10% coinsurance	30% coinsurance	

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 have a hospital stay	Facility fee (e.g., hospital room).	10% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Anesthesia and other ancillary fees will be paid in accordance with the hospital's network status.
If you need mental health, behavioral health or substance abuse services	Outpatient services	10% coinsurance for office visit and other outpatient services	30% coinsurance	Preauthorization is required for partial in-patient stays. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Rehabilitation services	10% coinsurance	30% coinsurance	Includes physical therapy, speech therapy and occupational therapy.
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	120 visits/calendar year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Durable medical equipment	10% coinsurance	30% coinsurance	Excludes vehicle modifications, home modifications and exercise equipment. Preauthorization is required for some items, dependent on cost. Verify what your plan requires.
	Hospice services	10% coinsurance	30% coinsurance	Benefit is for the terminally ill with an anticipated life expectancy of about months.
If your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance	
	Children's glasses	No coverage	No coverage	Covered by vision plan (VSP).
	Children's dental check-up	No coverage	No coverage	Covered by dental plan (Delta Dental).

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Nutritional supplements
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Private duty nursing
- Routine foot care
- Abortions or abortifacients

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Weight loss programs
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: If you want to continue your coverage after it ends, contact the HR/Benefits department. 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. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

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 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 [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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	$200
Specialist copayment	$ 0
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductible	$200
Copayment	$0
Coinsurance	$1,254
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,514**

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

The plan's overall deductible	$200
Specialist copayment	$0
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductible	$200
Copayment	$0
Coinsurance	$714
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$974**

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

The plan's overall deductible	$200
Specialist copayment	$ 0
Hospital * (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductible*	$0
Copayment	$0
Coinsurance*	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$90**

*The deductible is waived for services that are accident related. For services incurred within 72 hours of the accident, the first $1,000 is paid at 100%.

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