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 UMR Plan Advisors at 1-844-590-5963. 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 UMR Plan Advisors at 1-844-590-5963 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Tier 1: $250 person / $500 family; Tier 2 & 3 providers: $1,000 person / $2,000 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. For all providers: Preventive care, emergency room care, office visits, mental health/substance abuse outpatient services (excluding partial hospitalization), and prenatal and postnatal care services are covered before you meet your deductible. For Tier 2 providers: Urgent care is 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?	For Tier 1 providers: $2,000 person/$4,000 family; Tier 2 & 3 providers: $3,000 person / $6,000 family; For prescription drug copays: $3,000 person / $6,000 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?	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 1-844-590-5963 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 – Preferred PeaceHealth CIN Providers	Tier 2 - Participating Providers	Tier 3 - Non-Participating Providers	
		(You will pay the least)	(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	No charge	$25 copay per visit	Not covered	Deductible does not apply. Includes telemedicine consults.
	Specialist visit	No charge	$50 copay per visit	Not covered	
	Preventive care/screening/ immunization	No charge	No charge (preventive services) / 20% coinsurance (routine care)	Not covered	Deductible does not apply. 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)	No charge (office setting)/$225 copay outpatient	$25 copay PCP/ $50 copay Specialist; 20% coinsurance outpatient	Not covered	Deductible does not apply for office setting Diagnostic Testing or Imaging.
	Imaging (CT/PET scans, MRIs)	10% coinsurance (office setting)/ $225 copay (outpatient)	20% 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	$10 Copay (retail)/ $25 copay (mail order)	OptumRx Pharmacy: $15 copay (retail)/Not Covered (mail order)	Not covered	Deductible does not apply. Covers up to a 30-day supply (retail or specialty prescriptions); 90-day supply (mail order prescription). Mail order prescriptions are only covered when obtained from the PHSW Outpatient Pharmacy or PeaceHealth St. John Medical Center Outpatient Pharmacy. There is no charge or deductible for preventive drugs.
	Formulary drugs	20% copay ($25 minimum/$75 maximum) (retail)/ 16% copay ($62.50 minimum /$187.50 maximum (mail order)	OptumRx Pharmacy: 30% copay ($30 minimum/$90 maximum) (retail)/ Not Covered (mail order)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - Preferred PeaceHealth CIN Providers	Tier 2 - Participating Providers	Tier 3 - Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.optumrx.com	Non-Formulary drugs	30% copay ($40 minimum/$120 maximum) (retail)/ 25% copay ($100 minimum/$300 maximum) (mail order)	OptumRx Pharmacy: 40% copay ($50 minimum/$150 maximum) (retail) / Not Covered (mail order)	Not covered	Mandatory generic provision applies. Note that certain medications require preauthorization. Chronic Condition Management Program: There is no charge for certain preventive medications when participating members complete all program requirements & prescriptions filled at PeaceHealth/ZoomCare Employee Pharmacy, PHSW Outpatient Pharmacy or PeaceHealth St. John Medical Center Outpatient Pharmacy
	Specialty drugs	Contact PeaceHealth St. John Medical Center Outpatient Pharmacy for applicable cost.		Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$225 copay per visit	20% coinsurance	Not covered	Preauthorization is required. Deductible does not apply to Tier 1.
	Physician/surgeon fees	No charge	20% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	$150 copay per visit	$150 copay per visit	$150 copay per visit	Deductible does not apply. Tier 3 providers are paid at the Tier 2 provider level of benefits. Copay is waived if admitted to the hospital.
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	Tier 3 providers are paid at the Tier 2 provider level of benefits.
	Urgent care	$50 copay per visit	$75 copay per visit	Not covered	Deductible does not apply to Tier 2 providers. Copay applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay per day for the first 5 days	20% coinsurance	Not covered	Preauthorization is required. Tier 1 $200 copay per day for the first 5 days, then no charge. Deductible does not apply to Tier 1.
	Physician/surgeon fee	No charge	20% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - Preferred PeaceHealth CIN Providers	Tier 2 - Participating Providers	Tier 3 - Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	No charge per office visit/$225 copay per visit (partial hospitalization & other outpatient services)	$25 copay per office visit; 20% coinsurance (partial hospitalization & other outpatient services)	Not covered	Deductible does not apply to Tier 1 and Tier 2 outpatient services. Tier 2 deductible applies to partial hospitalization.
	Inpatient services	$200 copay per day for the first 5 days then no charge facility; no charge physician	20% coinsurance	Not covered	Preauthorization required. Deductible does not apply to Tier 1 inpatient services.
If you are pregnant	Office visits	No charge (prenatal) /10% coinsurance (postnatal)	No charge (prenatal services)/ 20% coinsurance (postnatal services)	Not covered	Preauthorization required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). Cost sharing does not apply to preventive services from a participating provider, for prenatal or postnatal services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count toward the mother's expense; therefore the family deductible amount may apply. Deductible does not apply to Tier 1 and Tier 2 postnatal services.
	Childbirth/delivery professional services	Delivery -$200 copay for the first 5 days then no charge for facility. Physicians are covered 100%	20% coinsurance	Not covered	
	Childbirth/delivery facility services	Delivery -$200 copay for the first 5 days then no charge for facility. Physicians are covered 100%	20% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - Preferred PeaceHealth CIN Providers	Tier 2 - Participating Providers	Tier 3 - Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Not covered	Preauthorization is required.
	Rehabilitation services	No Charge	20% coinsurance	Not covered	Physical, speech, occupational, respiratory, pulmonary, massage therapy and cardiac rehab limited to maximum of 30 visits per therapy per year.
	Habilitation services	No Charge	20% coinsurance	Not covered	
	Skilled nursing care	10% coinsurance	20% coinsurance	Not covered	Limited to 60 days per calendar year; Preauthorization is required.
	Durable medical equipment	10% coinsurance	20% coinsurance	Not covered	Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases.
	Hospice service	10% coinsurance	20% coinsurance	Not covered	Bereavement counseling is covered. Respite care limited to 120 hours per year.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	Deductible does not apply. Limited to 1 exam per calendar year.
	Children's glasses	Not covered	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered

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 & Child)
- Infertility treatment (except diagnosis)
- Long-term care
- Private-duty nursing (except for home health care & hospice)
- Routine eye care (Adult)
- Routine foot care (except for metabolic or peripheral vascular disease)

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

- Acupuncture
- Bariatric surgery (for the treatment of morbid obesity and obesity)
- Chiropractic care
- Hearing aids and exams
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Child)
- Weight loss programs (for the treatment of morbid obesity and obesity)

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 on how 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.

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 Tier 1 pre-natal care and a hospital delivery)

The plan's overall deductible	$250
Specialist copayment	$0
Hospital (facility) copayment	$200
Other coinsurance	10%

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

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,310**

Managing Joe's type 2 Diabetes
(a year of routine Tier 1 care of a well-controlled condition)

The plan's overall deductible	$250
Specialist copayment	$0
Hospital (facility) copayment	$200
Other coinsurance	10%

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

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$300**

Mia's Simple Fracture
(Tier 1 emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist copayment	$0
Hospital (facility) copayment	$200
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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$700
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,150**

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