



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](http://www.umr.com) or by calling 1-800-826-9781. 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](http://www.umr.com) or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <a href="#">deductible</a> ?	\$0 person / \$0 family Tier 1 \$250 person / \$1,000 family Tiers 2 & 3	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,950 person / \$7,900 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, penalties, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.umr.com">www.umr.com</a> or call 1-800-826-9781 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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	
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; 30% Coinsurance	Not covered	None
	<u>Specialist</u> visit	\$35 Copay per visit	\$50 Copay per visit; 30% Coinsurance	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge	No charge; Deductible Waived to age 19 or performed by OB/GYN; Not covered from age 19	Not covered	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	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% Coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$75 Copay per visit	\$75 Copay per visit; 30% Coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service for CT/MRIs.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	
<p>If you need drugs to treat your illness or condition.</p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>.</p>	Drug Annual Deductible	\$200 Individual \$400 Family	N/A	N/A	Annual pharmacy deductible waived for generic prescriptions if obtained from a Cleveland Clinic Pharmacy
	Drug Out-of-Pocket Maximum	\$3,950 per person/ \$7,900 family	N/A	N/A	Out-of-pocket limit applies after annual pharmacy deductible has been met.
	Generic drugs (Tier 1)	15% co-insurance at Cleveland Clinic pharmacies; 20% co-insurance at CVS Store pharmacies & CVS/caremark Mail Service Program	N/A	N/A	\$50 maximum copay per month supply filled at Cleveland Clinic pharmacies & at CVS Store pharmacies & CVS/caremark Mail Service Program
	Preferred brand drugs (Tier 2)	25% co-insurance at Cleveland Clinic pharmacies; 30% co-insurance at CVS Store pharmacies & CVS/caremark Mail Service Program	N/A	N/A	\$50 maximum copay per month supply filled at Cleveland Clinic pharmacies at CVS Store pharmacies & CVS/caremark Mail Service Program
	Non-preferred brand drugs (Tier 3)	45% co-insurance at Cleveland Clinic pharmacies; 50% co-insurance at CVS Store pharmacies & CVS/caremark mail Service Program	N/A	N/A	There is no monthly maximum co-pay for Tier 3 medications

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	
	<a href="#"><u>Specialty drugs</u></a> (Tier 4)	20% co-insurance	N/A	N/A	\$50 maximum co-pay per month supply filled at Cleveland Clinic pharmacies including Specialty and Home Delivery
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% Coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service for specific surgeries.
	Physician/surgeon fees	No charge	30% Coinsurance	Not covered	
If you need immediate medical attention	<a href="#"><u>Emergency room care</u></a>	\$250 Copay per visit	\$250 Copay per visit; Deductible Waived	\$250 Copay per visit; Deductible Waived	Copay may be waived if admitted
	<a href="#"><u>Emergency medical transportation</u></a>	No charge	No charge; Deductible Waived	No charge; Deductible Waived	\$25,000 Maximum benefit per occurrence Ambulance air
	<a href="#"><u>Urgent care</u></a>	\$50 Copay per visit	\$50 Copay per visit; Deductible Waived	\$50 Copay per visit; Deductible Waived	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 Copay per admission	\$350 Copay per admission; 30% Coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service.
	Physician/surgeon fee	No charge	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	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$35 Copay per visit	\$35 Copay per visit	Not covered	Preauthorization is required for Partial hospitalization. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service.
	Inpatient services	\$350 Copay per admission	\$350 Copay per admission	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service.
If you are pregnant	Office visits	No charge	No charge; Deductible Waived	Not covered	Cost sharing does not apply to certain 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	No charge	No charge	Not covered	
	Childbirth/delivery facility services	\$350 Copay per admission	\$350 Copay per admission	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	
If you need help recovering or have other special health needs	<a href="#"><u>Home health care</u></a>	No charge	No charge; Deductible Waived	Not covered	60 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service.
	<a href="#"><u>Rehabilitation services</u></a>	\$10 Copay per visit for first 20 visits; additional 15 visits 50% Coinsurance	30% Coinsurance	Not covered	35 Maximum visits per calendar year OT; 35 Maximum visits per calendar year PT; 35 Maximum visits per calendar year ST
	<a href="#"><u>Habilitation services</u></a>	Not covered	Not covered	Not covered	None
	<a href="#"><u>Skilled nursing care</u></a>	\$350 Copay per admission	\$350 Copay per admission; Deductible Waived	Not covered	60 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service.
	<a href="#"><u>Durable medical equipment</u></a>	20% Coinsurance	20% Coinsurance; Deductible Waived	Not covered	Preauthorization is required for DME in excess of \$500 for rentals & \$1,500 for purchases. If you don't get preauthorization, benefits could be reduced by 100% per occurrence.
	<a href="#"><u>Hospice service</u></a>	No charge	No charge; Deductible Waived	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	\$35 Copay per visit	\$35 Copay per visit; Deductible Waived	Not covered	1 Maximum exam per calendar year
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	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](#).)

<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Dental care (adult)</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
--	---	---

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

<ul style="list-style-type: none"><li>• Bariatric surgery (Tier 1 only)</li><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids (Tier 1 only)</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (adult)</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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.HealthCare.gov](http://www.HealthCare.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](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 on how 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.HealthCare.gov](http://www.HealthCare.gov). 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](http://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 in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$350
■ Other <a href="#">coinsurance</a>	0%

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	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0

#### What isn't covered

Limits or exclusions	\$70
The total Peg would pay is	\$470

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$350
■ Other <a href="#">coinsurance</a>	0%

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	
<a href="#">Deductibles*</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0

#### What isn't covered

Limits or exclusions	\$4,300
The total Joe would pay is	\$4,500

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$350
■ Other <a href="#">coinsurance</a>	0%

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	
<a href="#">Deductibles*</a>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0

#### What isn't covered

Limits or exclusions	\$10
The total Mia would pay is	\$310

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](http://www.umr.com) or call 1-800-826-9781.

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