UMR: CLARK COUNTY, NEVADA: 7670-00-414937 003, 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 1-800-395-7069. 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 1-800-395-7069 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** person / **$0** family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
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?	**$3,750** person / **$7,750** family Separate Rx limit: $2,000 person / $4,000 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 1-800-395-7069 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	Tier 2	Tier 3	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 Copay per visit	$20 Copay per visit	Not covered	None
	Specialist visit	$30 Copay per visit	$40 Copay per visit	Not covered	None
	Preventive care/screening/ immunization	No charge	No charge	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	Diagnostic test (x-ray, blood work)	No charge	$5 Copay per visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	$10 Copay per visit	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will result in no coverage.

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 drugs to treat your illness or condition. More information about prescription drug coverage is available at www.navitus.com.	Generic drugs (Tier 1)	$25 Copay per prescription (retail); $62.50 Copay per prescription (mail order)		Not covered	**$2,000** person / **$4,000** family annual Maximum out-of-pocket per calendar year Covers up to a 90-day supply The Plan offers a Copay Max program for **specialty** drugs included in the specialty tier and dispensed only through the specialty pharmacy, Lumicera. See SPD for Copay Max program description.
	Preferred brand drugs (Tier 2)	$50 Copay per prescription (retail); $125 Copay per prescription (mail order)			
	Non-preferred brand drugs (Tier 3)	$75 Copay per prescription (retail); $187.50 Copay per prescription (mail order)			
	Specialty drugs (Tier 4)	As stated above based upon drug class			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge Physician's Surgical Services; Not covered Ambulatory Surgical Facility	$75 Copay per procedure at an Ambulatory Surgical facility; $250 Copay per procedure for Physician's Surgical Services at other outpatient hospitals	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will result in no coverage.
	Physician/surgeon fees	No charge Physician's Surgical Services; Not covered Ambulatory Surgical Facility	$40 Copay per surgery for Physician's Surgical Services at an Ambulatory Surgical facility; No charge at other outpatient hospitals No charge	Not covered	
If you need immediate medical attention	Emergency room care	$500 Copay per visit	$500 Copay per visit	$500 Copay per visit	Copay may be waived if admitted
	Emergency medical transportation	Not covered	$50 Copay per trip	$50 Copay per trip	Copay may be waived if admitted; Preauthorization is required for Non-emergency services. If you don't get preauthorization, benefits will result in no coverage.
	Urgent care	$20 Copay per visit at UMC Quick Care only; Not covered all other facilities	$20 Copay per visit	$20 Copay per visit	You may be balance billed from Non-Plan Providers

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 a hospital stay	Facility fee (e.g., hospital room)	No charge	$350 Copay per day up to $1,750 per admission	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will result in no coverage.
	Physician/surgeon fee	No charge	No charge	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$10 Copay per office visit; No charge other outpatient services	$20 Copay per office visit; No charge other outpatient services	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will result in no coverage.
	Inpatient services	No charge	$350 Copay per day up to $1,750 per admission	Not covered	
If you are pregnant	Office visits	No charge	No charge	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	No charge	$350 Copay per day up to $1,750 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	Home health care	Not covered	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will result in no coverage.
	Rehabilitation services	$5 Copay per visit	$5 Copay per visit	Not covered	30 Maximum visits per calendar year OT Outpatient; 30 Maximum visits per calendar year PT Outpatient; 30 Maximum visits per calendar year ST Outpatient; 60 Maximum days per calendar year Inpatient; Preauthorization is required. If you don't get preauthorization, benefits will result in no coverage. Habilitation services for Learning Disabilities are not covered.
	Habilitation services	$5 Copay per visit	$5 Copay per visit	Not covered	
	Skilled nursing care	No charge	$250 Copay per admission	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will result in no coverage.
	Durable medical equipment	Not covered	No charge	Not covered	Purchases are limited to a single purchase of a type of DME, including repair/replacement, once every 3 years unless due to growth for leg, arm, back and neck braces. Preauthorization is required for DME for rentals or for purchases. If you don't get preauthorization, benefits will result in no coverage.
	Hospice service	No charge Inpatient; Not covered Outpatient	$350 Copay per day up to $1,750 per admission Inpatient; No charge Outpatient	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will result in no coverage.
If your child needs dental or eye care	Children's eye exam	Benefits are provided by EyeMed Visioncare	Benefits are provided by EyeMed Visioncare	Benefits are provided by EyeMed Visioncare	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	No charge	No charge	Not covered	$2,000 Maximum benefit per calendar year

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
- Cosmetic surgery
- Routine eye care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Dental care (Adult) (Tier 1 & Tier 2 only)
- Private-duty nursing
- Weight loss programs
- Routine foot care (Tier 1 & Tier 2 only)

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

- Bariatric surgery (Tier 1 & Tier 2 only)
- Chiropractic care (Tier 2 only)
- Hearing aids (Tier 2 only)
- Infertility treatment (Tier 1 & Tier 2 only)

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	$0
Specialist copayment	N/A
Hospital (facility) coinsurance	0%
Other coinsurance	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	
Deductibles	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$70**

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

The plan's overall deductible	$0
Specialist copayment	N/A
Hospital (facility) coinsurance	0%
Other coinsurance	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	
Deductibles*	$0
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$300
The total Joe would pay is	**$1,900**

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

The plan's overall deductible	$0
Specialist copayment	N/A
Hospital (facility) coinsurance	0%
Other coinsurance	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	
Deductibles*	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,200
The total Mia would pay is	**$1,700**

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

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