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 844-212-1134. 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 1-844-212-1134 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,000 person / $4,000 family In-network $4,000 person / $8,000 family Out-of-network	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. Some copays and Preventive care 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 deductibles for specific services.
What is the out–of–pocket limit for this plan?	$4,000 person / $8,000 family In-network $8,000 person / $16,000 family Out-of-network	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 1-844-212-1134 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 (a 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.

Additional cost-saving programs may be available to plan participants that are not described in this document. Contact your employer for additional details

All 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
		In-network (You will pay the least)	Out-of-network (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	$0 Copay for Premium Designated (Tier 1) PCP and Nextera Providers $30 Copay for all other in network PCP Providers	50% Coinsurance	None
	Specialist visit	$30 Copay for Premium Designated (Tier 1) Specialists $60 Copay for all other in network Specialists	50% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	50% 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)	$50 Copay	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	$200 Copay	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (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.caremark.com	Generic drugs (Tier 1)	$10 copay for retail (30 day supply), $25 copay for 90 day retail/mail order fill Deductible Does Not Appply	Not Covered	Specialty Drugs are only Available under the 30 Day Retail Program. CVS Customer Service: 1-855-297-2178 PrudentRx Copay Program for Specialty Medications In order to provide a comprehensive and cost-effective prescription drug program for you and your family, St. Vrain Valley School District has contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications. The PrudentRx Copay Program assists members by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% co-insurance. However, enrolled members who get copay card for their specialty medication (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program. For more information, please see the additional notes on page 7.
	Preferred brand drugs (Tier 2)	20% Coinsurance up to $50 for retail (30 day supply), 20% Coinsurance up to $125 for 90 day retail/mail order fill Deductible Does Not Apply	Not Covered	
	Non-preferred brand drugs (Tier 3)	25% Coinsurance up to $75 for retail (30 day supply), 25% Coinsurance up to $187.50 for 90 day retail/mail order fill Deductible Does Not Apply	Not Covered	
	Specialty drugs (Tier 4)	30% Coinsurance* for retail (30 day supply), not eligible for 90 day retail/mail order fill Deductible Does Not Apply *See PrudentRx Copay Program details	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	None
If you need immediate medical attention	Emergency room care	$200 Copay	$200 Copay	In-network deductible applies to Out-of-network benefits; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service for Non-emergency.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits
	Urgent care	$75 Copay	20% Coinsurance	In-network deductible applies to Out-of-network benefits
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	50% 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 fee	20% Coinsurance	50% Coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$30 Copay	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service for Partial hospitalization.
	Inpatient services	20% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you are pregnant	Office visits	20% Coinsurance	50% Coinsurance	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	20% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	50% Coinsurance	60 Maximum visits per calendar year combined with Private-duty nursing; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Rehabilitation services	$30 Copay	50% Coinsurance	30 Maximum visits per calendar year OT; 30 Maximum visits per calendar year PT; 30 Maximum visits per calendar year ST
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% Coinsurance	50% Coinsurance	60 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Durable medical equipment	20% Coinsurance	50% Coinsurance	Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases. If you don't get preauthorization, benefits could be reduced by 50% per occurrence.
	Hospice service	20% Coinsurance	50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	$10 Copay per visit; Deductible Waived	$10 Copay per visit; Deductible Waived	1 Maximum exam every 24 months; $75 Maximum benefit every 24 months Out-of-network
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	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.)

- Acupuncture
- Bariatric surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Cosmetic surgery (if medically necessary)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Outpatient care)
- Routine eye care (Adult)

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 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.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 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.

PrudentRx Program Additional Information
Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Copay Program will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible members are enrolled in the PrudentRx program via an easy twostep process: 1) The first step of enrollment is already complete as your member information is on file with PrudentRx and 2) You need to call PrudentRx at 1-800-578-4403 within the next 5 days to register for any copay assistance available from drug manufacturers. You can choose to opt out of the program and you must call 1-800-578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx at 1-800-578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx program. If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at 1-800-578-4403 to
address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible. Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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	$2,000
Specialist copay	$60
Hospital (facility) coinsurance	20%
Other coinsurance	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)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$60
Coinsurance	$500
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	$2,560

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

The plan's overall deductible	$2,000
Specialist Copay	$60
Hospital (facility) coinsurance	20%
Other coinsurance	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)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,200
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6000
The total Joe would pay is	$7,260

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

The plan's overall deductible	$2,000
Specialist Copay	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,900
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,960

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