**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 1-844-212-1134. 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?** | $2,500 person / $5,000 family In-network<br>$5,000 person / $10,000 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. 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?** | $5,000 person / $9,000 family In-network<br>$10,000 person / $18,000 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 (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 |
|---|---|---|---|---|
| | | In-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 | No charge Premium Designated Providers;<br>$30 copay per visit<br>Non-premium Designated Providers; deductible waived | 50% coinsurance | None |
| | Specialist visit | $30 copay per visit Premium Designated Providers;<br>$60 copay per visit<br>Non-premium Designated Providers; deductible waived | 50% coinsurance | None |
| | Preventive care/screening/ immunization | No charge;<br>deductible waived | 50% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test<br>(x-ray, blood work) | $50 copay per visit;<br>deductible waived | 50% coinsurance | None |
| | Imaging<br>(CT/PET scans, MRIs) | $200 copay per visit;<br>deductible waived | 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 Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition.**<br><br>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<br>Deductible Does Not Apply | Not Covered | Specialty Drugs are only Available under the 30 Day Retail Program.<br>CVS Customer Service: 1-855-297-2178<br><br>PrudentRx Copay Program for Specialty Medications<br>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.<br><br>PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.<br><br>For more information, please see the additional notes on page 8. |
| | 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<br>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<br>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<br>Deductible Does Not Apply<br><br>*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. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | |
| **If you need immediate** | Emergency room care | $500 copay per visit; deductible waived | $500 copay per visit; deductible waived | Copay may be waived if admitted |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| **medical attention** | Emergency medical transportation | 20% coinsurance | 20% coinsurance | In-network deductible applies to Out-of-network benefits; Preauthorization is required for Non-emergent services. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. |
| | Urgent care | $75 copay per visit; deductible waived | 50% coinsurance | None |
| **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 fees | 20% coinsurance | 50% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $0 copay per visit; deductible waived office visits; 20% coinsurance other outpatient services | $30 copay per visit; deductible waived office visits; 20% coinsurance other outpatient services | In-network deductible applies to Out-of-network benefits other outpatient services; Preauthorization is required for Partial hospitalization. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. |
| | Inpatient services | 20% coinsurance | 20% coinsurance | 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. |
| **If you are pregnant** | Office visits | No charge; deductible waived | 50% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | 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 per visit; deductible waived | 50% coinsurance | Habilitation services for Learning Disabilities are not covered. |
| | Habilitation services | $30 copay per visit; deductible waived | 50% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | 60 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. |
| | 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. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| | 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 exam every 24 months; $75 benefit every 24 months for 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
- Non-emergency care when traveling outside the U.S.
- 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 – 24 visits per calendar year
- Cosmetic surgery – if medically necessary
- Hearing aids – 1 per ear every 5 years
- Private-duty nursing (Outpatient care) - 60 visits per calendar year combined with Home health care
- Routine eye care (Adult) – 1 exam every 24 months; $75 benefit every 24 months for Out-of-network 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 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://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

**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.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-212-1134.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-844-212-1134.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-212-1134.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-844-212-1134.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-212-1134.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-844-212-1134.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-844-212-1134.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-844-212-1134.

## 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 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 | $2,500 |
| Specialist copayment | $30 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $2,500 |
| Copayments | $300 |
| Coinsurance | $1,700 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Peg would pay is** | **$4,570** |

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

| | |
|---|---|
| The plan's overall deductible | $2,500 |
| Specialist copayment | $30 |
| 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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $4,300 |
| **The total Joe would pay is** | **$4,400** |

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

| | |
|---|---|
| The plan's overall deductible | $2,500 |
| Specialist copayment | $30 |
| 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** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $700 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Mia would pay is** | **$1,710** |

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 or call 1-844-212-1134.

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