



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, www.myurhealth.com. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-866-678-3297 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Provider : \$3,000/individual or \$6,000/family per benefit period. Nonpreferred Provider : \$6,000/individual or \$11,000/family per benefit period.	Generally, you must pay all of the costs from providers up to the deductible , amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care by a preferred provider 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?	Preferred Provider : \$6,000/individual or \$11,000/family per benefit period. Nonpreferred Provider : \$11,000/individual or \$33,000/family per benefit period.	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 for failure to obtain pre-certification for services, 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.myurhealth.com or call 1-866-678-3297 for a list of network providers.	This plan uses a provider network . You will pay less if you use a preferred provider in the plan's network . You will pay the most if you use a nonpreferred 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 preferred provider might use a nonpreferred 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
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	<u>Primary care</u> visit to treat an injury or illness	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Virtual visit (telehealth) benefits available.
	<u>Specialist</u> visit	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Virtual visit (telehealth) benefits available.
	<u>Preventive care</u> / <u>screening</u> /immunization	0% <u>coinsurance</u> (<u>deductible</u> does not apply)	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None.
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-certification</u> is required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at: Non-Specialty Drugs: www.caremark.com or call 1-855-220-5725. Specialty Drugs: archimedesrx.com or call 1-888-504-5563.	Generic drugs	Retail: \$10 <u>copayment</u> /prescription Mail order: \$20 <u>copayment</u> /prescription	Retail: \$10 <u>copayment</u> /prescription Mail order: Not covered	<u>Copayment</u> applies to a 30-day supply Retail and <u>Specialty drugs</u> or 31-90 day supply Mail-Order prescription. <u>Copayment</u> , <u>coinsurance</u> and <u>deductible</u> do not apply to preventive drugs required by the Affordable Care Act.
	Preferred drugs	Retail: \$25 <u>copayment</u> /prescription or 30% <u>coinsurance</u> , whichever is greater, up to a \$50 maximum/prescription Mail order: \$65 <u>copayment</u> /prescription or 30% <u>coinsurance</u> , whichever is greater, up to a \$125 maximum/prescription	Retail: \$25 <u>copayment</u> /prescription or 50% <u>coinsurance</u> , whichever is greater, up to a \$50 maximum/prescription Mail order: Not covered	If you use a non-participating pharmacy, you must also pay the difference in cost between a participating and the non-participating pharmacy. If you purchase a brand name drug when a generic drug is available, you must pay difference in cost.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.myurhealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition (continued)</p> <p>More information about prescription drug coverage is available at:</p> <p>Non-Specialty Drugs www.caremark.com or call 1-855-220-5725.</p> <p>Specialty Drugs: archimedesrx.com or call 1-888-504-5563.</p>	Non-preferred drugs	<p>Retail: \$50 copayment/prescription or 30% coinsurance, whichever is greater, up to a \$100 maximum/prescription</p> <p>Mail order: \$125 copayment/prescription or 30% coinsurance, whichever is greater, up to a \$250 maximum/prescription</p>	<p>Retail: \$50 copayment/prescription or 50% coinsurance, whichever is greater up to a \$100 maximum/prescription</p> <p>Mail order: Not covered</p>	<p>Copayment applies to a 30-day supply Retail and Specialty drugs or 31-90 day supply Mail-Order prescription.</p> <p>Copayment and coinsurance do not apply to preventive drugs required by the Affordable Care Act.</p> <p>If you use a non-participating pharmacy, you must also pay the difference in cost between a participating and the non-participating pharmacy.</p>
	Specialty drugs	<p>Retail and Mail order: \$75 copayment/prescription or 20% coinsurance, whichever is greater, up to a \$200 maximum/prescription</p>	<p>Retail and Mail order: Not covered</p>	<p>If you purchase a brand name drug when a generic drug is available, you must pay difference in cost.</p>
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Pre-certification is required for some surgeries.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None.
<p>If you need immediate medical attention</p>	Emergency room care	30% coinsurance	preferred provider benefit applies	None.
	Emergency medical transportation	30% coinsurance	preferred provider benefit applies	None.
	Urgent care	30% coinsurance	50% coinsurance	None.
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Pre-certification is required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.myurhealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	Pre-certification is required for some outpatient services.
	Inpatient services	30% coinsurance	50% coinsurance	Pre-certification is required.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Dependent daughters are covered for this benefit. Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Home health care visits limited to 120 visits per benefit period. Pre-certification is required.
	Rehabilitation services	30% coinsurance	50% coinsurance	Chiropractic, physical, and occupational therapy combined limited to 24 visits per benefit period, unless medically necessary.
	Habilitation services	30% coinsurance	50% coinsurance	Limit does not apply to mental health, behavioral health, or substance abuse services, including autism.
	Skilled nursing care	30% coinsurance	50% coinsurance	Skilled nursing care limited to 120 days per benefit period. Pre-certification is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs (continued)	Durable medical equipment	30% coinsurance	50% coinsurance	Pre-certification is required for durable medical equipment costing more than \$1,500.
	Hospice services	30% coinsurance	50% coinsurance	Pre-certification is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None.
	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](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Dental care
- Infertility treatment (benefits available through WINFertility, Inc. <http://managed.winfertility.com>)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye 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.)

- Acupuncture, limited to 20 visits per benefit period
- Bariatric surgery, [preferred provider](#) only
- Chiropractic care, combined with physical and occupational therapy, limited to 24 visits per benefit period, unless medically necessary
- Hearing aids, limit one hearing aid per ear every 3 years

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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](#). For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 Standards? 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 1-866-678-3297.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-678-3297.

Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijjigo holne' 1-866-678-3297.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-678-3297 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-678-3297.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-678-3297.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-678-3297.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, á'gang 1-866-678-3297.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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	\$3,000
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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 **\$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$10
Coinsurance	\$2,900

What isn't covered

Limits or exclusions **\$60**

The total Peg would pay is **\$5,970**

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	\$3,000
Copayments	\$200
Coinsurance	\$200

What isn't covered

Limits or exclusions **\$20**

The total Joe would pay is **\$3,420**

Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	\$2,800
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions **\$0**

The total Mia would pay is **\$2,800**

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: 1-866-678-3297.