# JEFFERSON CITY SCHOOL DISTRICT: 7670-00-410722 001



**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 1-800-826-9781. 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 or call 1-800-826-9781 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,000** person / **$2,000** family In-network<br>**$2,000** person / **$4,000** 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?** | **$3,000** person / **$6,000** family In-network<br>**$6,000** person / **$12,000** 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?** | Copayments for medical services, 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 1-800-826-9781 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. |

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 (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 | $25 Copay per visit; Deductible Waived | 40% Coinsurance | None |
| | Specialist visit | $35 Copay per visit; Deductible Waived | 40% Coinsurance | None |
| | Preventive care/screening/ immunization | No charge; Deductible Waived | 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) | 20% Coinsurance | 40% Coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. |

| 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.**<br><br>More information about prescription drug coverage is available at www.optumrx.com. | Generic drugs (Tier 1) | $10 1-30 Day Supply<br>$20 90 Day Supply | Not Covered | Specialty Medications: Specialty medications must be ordered through Briova Rx at 1-800-850-9122. Limited to a 30-day supply and may require prior authorization.<br><br>Manufacturer Copay Assistance Program (MCAP): Some specialty medications may qualify for third-party copayment assistance programs which could lower your out of pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, the Member shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copayment or Coinsurance amounts that are applied to a manufacturer coupon or rebate. |
| | Preferred brand drugs (Tier 2) | $30 1-30 Day Supply<br>$60 90 Day Supply | Not Covered | |
| | Non-preferred brand drugs (Tier 3) | $50 1-30 Day Supply<br>$100 90 Day Supply | Not Covered | |
| | Specialty drugs (Tier 4) | $75 1-30 Day Supply Less Than $1,000<br><br>$125 1-30 Day Supply Over $1,000 | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance | 40% Coinsurance | None |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $100 Copay per visit;<br>20% Coinsurance | $100 Copay per visit;<br>20% Coinsurance | In-network deductible applies to Out-of-network benefits;<br>Copay may be waived if admitted |
| | Emergency medical transportation | 20% Coinsurance | 20% Coinsurance | In-network deductible applies to Out-of-network benefits |

| 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) | |
| | Urgent care | $35 Copay per visit; 20% Coinsurance | 40% Coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $100 Copay per admission; 20% Coinsurance | $100 Copay per admission; 40% Coinsurance | Preauthorization is required. |
| | Physician/surgeon fee | 20% Coinsurance | 40% Coinsurance | |
| **If you have mental health, behavioral health, or substance abuse needs** | Outpatient services | $25 Copay per visit; Deductible Waived office visits; 20% Coinsurance other outpatient services | 40% Coinsurance | Preauthorization is required for Partial hospitalization. |
| | Inpatient services | $100 Copay per admission; 20% Coinsurance | $100 Copay per admission; 40% Coinsurance | Preauthorization is required. |
| **If you are pregnant** | Office visits | No charge; Deductible Waived | 40% 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 | 40% Coinsurance | |

| 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) | |
| | Childbirth/delivery facility services | $100 Copay per admission; 20% Coinsurance | $100 Copay per admission; 40% Coinsurance | |

| 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 help recovering or have other special health needs** | Home health care | 20% Coinsurance | 40% Coinsurance | 100 Maximum visits per plan year; Preauthorization is required. |
| | Rehabilitation services | $35 Copay per visit; Deductible Waived | 40% Coinsurance | 60 Maximum visits per plan year OT; 60 Maximum visits per plan year PT; 60 Maximum visits per plan year ST; Preauthorization is required. |
| | Habilitation services | Not covered | Not covered | None |
| | Skilled nursing care | $100 Copay per admission; 20% Coinsurance | $100 Copay per admission; 40% Coinsurance | 70 Maximum days per plan year; Preauthorization is required. |
| | Durable medical equipment | 20% Coinsurance | 40% Coinsurance | Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases. |
| | Hospice service | 20% Coinsurance | 40% Coinsurance | 100 Maximum visits per plan year |
| **If your child needs dental or eye care** | Children's eye exam | No charge; Deductible Waived | Not covered | 1 Maximum exam per plan year |
| | 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
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- 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.)**

- Bariatric surgery
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (if medically necessary)
- 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.HealthCare.gov 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.

*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 | $1,000 |
| Specialist copayment | $35 |
| Hospital (facility) copayment | $100 |
| 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 | $1,000 |
| Copayments | $0 |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,060** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist copayment | $35 |
| Hospital (facility) copayment | $100 |
| 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* | $1,000 |
| Copayments | $970 |
| Coinsurance | $372 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$2,398** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist copayment | $35 |
| Hospital (facility) copayment | $100 |
| 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* | $1,000 |
| Copayments | $245 |
| Coinsurance | $283 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,528** |

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 1-800-826-9781.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

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