UMR: BAYLOR UNIVERSITY: PPO PLAN

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?	**$500** person / **$1,500** family In-network **$900** person / **$2,700** 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?	Yes.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out–of–pocket limit for this plan?	**$4,000** person / **$8,500** family In-network **$6,150** person / **$17,000** family Out-of-network Other limits apply – see the chart that starts on page 2	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 1-800-826-9781 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 (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	$30 Copay per visit; Deductible Waived	30% Coinsurance	None
	Specialist visit	$60 Copay per visit; Deductible Waived	30% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	30% 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. No Charge for child immunizations Out-of-Network through the 6th birthday. Copay is required for routine X-ray and other procedures for physician office visit only.
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	None

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 per prescription (retail); $25 Copay per prescription (mail order)	See Limitations & Exceptions	**$2,500** person / **$5,000** family annual Maximum out-of-pocket per calendar year Out-of-Network or international claims must be submitted to CVS/Caremark as a manual/paper claim within 365 days from the date of the claim and will be reimbursed at the In-Network discounted rate minus the applicable copays. Specialty drugs from CVS Specialty only. Limit 30 day supply.
	Preferred brand drugs (Tier 2)	$40 Copay per prescription (retail); $100 Copay per prescription (mail order)	See Limitations & Exceptions	
	Non-preferred brand drugs (Tier 3)	$80 Copay per prescription (retail); $200 Copay per prescription (mail order)	See Limitations & Exceptions	
	Specialty drugs (Tier 4)	$120 Copay per prescription	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; 20% Coinsurance; Deductible Waived facility; 20% Coinsurance physician	$100 Copay per visit; 20% Coinsurance; Deductible Waived facility; 20% Coinsurance physician	Copay may be waived if admitted
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	$60 Copay per visit; Deductible Waived	30% Coinsurance	None

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 have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	$300 Deductible per admission In-network; $350 Deductible per admission Out-of-network; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service Out-of-network.
	Physician/surgeon fee	20% Coinsurance	40% Coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$30 Copay per visit; Deductible Waived office visits; 20% Coinsurance other outpatient services	30% Coinsurance office visits; 40% Coinsurance other outpatient services	Preauthorization is required for certain services.
	Inpatient services	20% Coinsurance	40% Coinsurance	$300 Deductible per admission In-network; $350 Deductible per admission Out-of-network; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service Out-of-network.
If you are pregnant	Office visits	$30 Copay per visit PCP; $60 Copay per visit Specialist for initial visit only; Deductible Waived	30% 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). $300 Deductible per admission In-network; $350 Deductible per admission Out-of-network
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	
	Childbirth/delivery facility 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)	
If you need help recovering or have other special health needs	Home health care	No charge; Deductible Waived	30% Coinsurance	90 Maximum visits per calendar year; Preauthorization is required.
	Rehabilitation services	$30 Copay per visit PCP; $60 Copay per visit Specialist; Deductible Waived office therapy; 20% Coinsurance hospital therapy	30% Coinsurance office therapy; 40% Coinsurance hospital therapy	90 Maximum visits per calendar year; If your plan excludes Learning Disabilities, habilitation services for learning disabilities are not covered, please refer to your plan document.
	Habilitation services	$30 Copay per visit PCP; $60 Copay per visit Specialist; Deductible Waived office therapy; 20% Coinsurance hospital therapy	30% Coinsurance office therapy; 40% Coinsurance hospital therapy	
	Skilled nursing care	No charge; Deductible Waived	30% Coinsurance	90 Maximum days per calendar year; Preauthorization is required.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	None
	Hospice service	No charge; Deductible Waived	30% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	$30 Copay per visit PCP; $60 Copay per visit Specialist; Deductible Waived	30% Coinsurance	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 Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine foot care

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-826-9781.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-826-9781.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-826-9781.

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	$500
Specialist copayment	$60
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*	$800
Copayments	$40
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,200**

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

The plan's overall deductible	$500
Specialist copayment	$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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$1,000
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,600**

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

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

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

*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.