# UMR: WINDSTREAM SERVICES, LLC.: 400 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 1-844-368-6189. 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 1-844-368-6189 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$400** person / **$800** family In-network<br>**$2,500** person / **$5,000** 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. In-network PCP Office services and the following services when rendered by an In-Network provider: Preventive care services, urgent care, chemotherapy and radiation therapy, chiropractic services, dialysis treatment, infusion therapy, physical therapy, occupational therapy, and speech therapy 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?** | **$2,200** person / **$4,400** family In-network<br>**$4,400** person / **$8,800** 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 1-844-368-6189 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 | $20 Copay per visit; Deductible Waived | 40% Coinsurance | None |
| | Specialist visit | $40 Copay per visit; Deductible Waived | 40% Coinsurance | None |
| | Preventive care/screening/ immunization | No charge; Deductible Waived | 40% Coinsurance | At all times this plan will comply with the Patient Protection and Affordable Care Act. The list of services included as Standard Preventive Care may change from time to time depending on government guidelines. A current listing of required preventive care can be accessed at: www.healthcare.gov/center/regulations/revention.html. 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 |

| 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 test** | Diagnostic test (x-ray, blood work) | 20% Coinsurance | 40% Coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. |
| **If you need drugs to treat your illness or condition.**<br><br>More information about prescription drug coverage is available at | Generic drugs (Tier 1) | Retail: $10 copay<br>Mail Order: $25 copay | Retail: $10 copay<br>Mail Order: Not covered | 30-day supply (retail); 90-day supply (mail order and at Walgreens locations). Mail order mandatory for maintenance drugs after 2 retail fills. No coverage for out-of-network mail order. Specialty medications are required to be filled through Accredo, Express Scripts' Specialty Pharmacy, after 1 retail fill. Some drugs require prior authorization or step therapy. If necessary authorization is not obtained, the drug may not be covered |
| | Preferred brand drugs (Tier 2) | Retail: $30 copay<br>Mail Order: $75 copay | Retail: $30 copay<br>Mail Order: Not covered | |
| | Non-preferred brand drugs (Tier 3) | Retail: $60 copay<br>Mail Order: $150 copay | Retail: $60 copay<br>Mail Order: Not covered | |

| 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) | |
| www.express-scripts.com. | Specialty drugs (Tier 4) | Generic Drugs: Retail: $10 copay; Mail Order: $25 copay<br><br>Preferred Drugs: Retail: $30 copay; Mail Order: $75 copay<br><br>Non-preferred Drugs: Retail: $60 copay; Mail Order: $150 copay | Generic Drugs: Retail: $10 copay<br><br>Preferred Drugs: Retail: $30 copay<br><br>Non-preferred Drugs: Retail: $60 copay<br><br>Mail Order: Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance | 40% Coinsurance | Preauthorization is required for outpatient surgeries. |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $150 Copay per visit; 20% Coinsurance | $150 Copay per visit; 20% Coinsurance | In-network deductible applies to Out-of-network benefits; Copay may be waived if admitted |
| | Emergency medical transportation | 20% Coinsurance | 20% Coinsurance | In-network deductible applies to Out-of-network benefits |
| | Urgent care | $50 Copay per visit; Deductible Waived | 40% Coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% Coinsurance | 40% Coinsurance | Preauthorization is required for inpatient stays. |

| 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 fee | 20% Coinsurance | 40% Coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 Copay per visit; Deductible Waived Office visits; 20% Coinsurance other outpatient services | 40% Coinsurance | None |
| | Inpatient services | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. Residential treatment centers are limited to 120 visits per calendar year. |
| **If you are pregnant** | Office visits | Prenatal - No charge; Deductible Waived Postnatal – 20% coinsurance | 40% Coinsurance | Cost sharing does not apply to certain preventive services such as prenatal care. 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). Routine obstetrical ultrasound is limited to one ultrasound per pregnancy. |
| | Childbirth/delivery professional services | 20% Coinsurance | 40% Coinsurance | |
| | Childbirth/delivery facility services | 20% Coinsurance | 40% Coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% Coinsurance | 40% Coinsurance | 120 Maximum visits per calendar year; Preauthorization is required. |
| | Rehabilitation services | $40 Copay per visit; Deductible Waived | 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) | |
| | Habilitation services | $40 Copay per visit; Deductible Waived | 40% Coinsurance | If your plan excludes Learning Disabilities, habilitation services for learning disabilities are not covered, please refer to your plan document. |
| | Skilled nursing care | 20% Coinsurance | 40% Coinsurance | 120 Maximum days per calendar year; Preauthorization is required. |
| | Durable medical equipment | 20% Coinsurance | 40% Coinsurance | Preauthorization is required for DME in excess of $500 for rentals or purchases. |
| | Hospice service | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. |
| **If your child needs dental or eye care** | Children's eye exam | Not charge | Not covered | Coverage is limited to eligible preventive care services for children under age six. |
| | Children's glasses | Not covered | Not covered | No coverage for eyeglasses under the medical benefit plan. Additional services may be available under a separate vision benefit plan. |
| | Children's dental check-up | Not covered | Not covered | No coverage for dental check-ups under the medical benefit plan. Additional services may be available under a separate dental benefit plan. |

## 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
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- 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
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Private-duty nursing (Outpatient care)

**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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.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. For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. 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 1-844-368-6189.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-368-6189.
Chinese (中文): 如果需要中文的帮助， ☒☒打☒个号☒ 1-844-368-6189.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-368-6189.

***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** | **$400** |
| **Specialist copayment** | **$40** |
| **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 | $400 |
| Copayments | $0 |
| Coinsurance | $1,800 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Peg would pay is** | **$2,270** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$400** |
| **Specialist copayment** | **$40** |
| **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* | $400 |
| Copayments | $500 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,020** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$400** |
| **Specialist copayment** | **$40** |
| **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* | $400 |
| Copayments | $300 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,000** |

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 1-844-368-6189.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.