**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services **Coverage Period: 10/01/2023 – 12/31/2023**

**UMR: CITY OF WOODSTOCK, GEORGIA: 7670-00-411860 002 Coverage for:** Individual + Family **| Plan Type:** PPO



**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](http://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](http://www.umr.com/) or call 1-800-826-9781 to request a copy.

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| **Important Questions** | **Answers** | **Why this Matters:** |
| **What is the overall deductible?** | **$1,500** person / **$4,500** family In-network  **$6,000** person / **$18,000** 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?** | **$1,500** person / **$4,500** family In-network  **$14,000** person / **$42,000** 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](http://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. |

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| Description: Exclamation | All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies. |

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| **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 | $15 Copay per visit Premium providers; $20 Copay per visit Premium providers physician after hours office visit; $25 Copay per visit Non-premium providers; $30 Copay per visit Non-premium providers  physician after hours office visit; Deductible Waived | 40% Coinsurance;  Not covered after hours office visit | None |
| Specialist visit | $25 Copay per visit Premium  providers & Premium providers physician after hours office visit;  $35 Copay per visit Non- premium providers & Non- premium providers physician after hours office visit;  Deductible Waived | 40% Coinsurance;  Not covered after hours office visit | None |
| Preventive care/screening/ immunization | No charge; Deductible Waived | 40% 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. |
| **If you have a test** | Diagnostic test  (x-ray, blood work) | No charge; Deductible Waived Office setting;  $250 Copay per visit Outpatient setting | 40% Coinsurance | None |
| Imaging  (CT/PET scans, MRIs) | No charge; Deductible Waived  Office setting;  $250 Copay per visit Outpatient setting | 40% Coinsurance | None |

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| **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)** |
|  | Generic drugs (Tier 1) | $15 copay at First Choice  $25 copay at Non-First Choice | N/A | ACA Medications only be filled at First Choice Pharmacies.  Specialty medications limited to 30 day supply. Local Retail pharmacies limited to 30 day supply.  The plan has adopted the Southern Scripts Variable CopayTM Program to help members who utilize manufacturer copay program save money on prescription drugs. Under the Variable CopayTM Program, your out-of-pocket cost for prescription drugs may be reduced or eliminated by a drug manufacturer’s copay subsidy. If you are eligible to receive a manufacturer copay subsidy for a drug, your copay obligation for that drug will be the maximum manufacturer copay subsidy for that drug.  Note: Any manufacturer copay subsidy obtained under the Variable CopayTM Program will not accumulate toward your deductible or out of pocket costs. If you are not eligible to receive a manufacturer copay subsidy your copay obligation will be the copay amount listed for the drug in the standard formulary under the plan. Note: if you are eligible for a manufacturer copay subsidy for a drug but fail to obtain the subsidy, your copay obligation  - and the out-of-pocket cost you may be required to pay – will be the maximum manufacturer copay subsidy for that drug. A detailed schedule of subsidies available through the manufacturer copay programs under the Variable CopayTM Program is available at crxspecialty.com or may be  access free of charge by contacting (877)646- 1716. |
|  | Preferred brand drugs (Tier 2) | $30 copay at First Choice  $40 copay at Non-First Choice | N/A |
| **If you need drugs to treat your illness or condition.** |  |  |  |
| Non-preferred brand drugs (Tier 3) | $60 copay at First Choice  $70 copay at Non-First Choice | N/A |
| More information about prescription drug coverage is available at www.southerns cripts.net | Specialty drugs (Tier 4) | $15 copay for generic  $30 copay for preferred brand  $60 copay for non-preferred brand | N/A |
|  | Facility fee (e.g., ambulatory surgery center) | $250 Copay per visit | 40% Coinsurance | Preauthorization is required. If you don’t  get preauthorization, benefits could be |

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| **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 outpatient**  **surgery** | Physician/surgeon fees | No charge | 40% Coinsurance | reduced by $250 of the total cost of the service. |
| **If you need immediate medical attention** | Emergency room care | $150 Copay per visit; Deductible Waived | $150 Copay per visit; Deductible Waived | Copay may be waived if admitted |
| Emergency medical transportation | No charge; Deductible Waived | No charge; Deductible Waived | None |
| Urgent care | $60 Copay per visit; Deductible Waived | 40% Coinsurance | None |
| **If you have a hospital stay** | Facility fee  (e.g., hospital room) | $250 Copay per admission | 40% Coinsurance | Preauthorization is required. If you don’t get preauthorization, benefits could be reduced by $250 of the total cost of the service. |
| Physician/surgeon fee | No charge | 40% Coinsurance |
| **If you have mental health, behavioral health, or substance abuse services** | Outpatient services | $15 Copay per office visit Premium providers; $20 Copay per office visit Premium providers physician after hours office visit;$25 Copay per office visit Non-premium providers;  $30 Copay per office visit Non- premium providers physician after hours office visit; Deductible Waived office visits; No charge other outpatient services | 40% Coinsurance;  Not covered after hours office visit | Preauthorization is required for Partial hospitalization. If you don’t get preauthorization, benefits could be reduced by $250 of the total cost of the service. |

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| **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)** |
|  | Inpatient services | $250 Copay per admission | 40% Coinsurance | Preauthorization is required. If you don’t get preauthorization, benefits could be reduced by $250 of the total cost of the  service. |
| **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 | No charge | 40% Coinsurance |
| Childbirth/delivery facility services | $250 Copay per admission | 40% Coinsurance |
| **If you need help recovering or have other special health needs** | Home health care | No charge; Deductible Waived | 40% Coinsurance | 120 Maximum visits per calendar year; Preauthorization is required. If you don’t get preauthorization, benefits could be reduced by $250 of the total cost of the service. |
| Rehabilitation services | $35 Copay per visit; Deductible Waived | 40% Coinsurance | None |
| Habilitation services | $35 Copay per visit; Deductible Waived | 40% Coinsurance | Habilitation services for Learning Disabilities are not covered. |
| Skilled nursing care | No charge; Deductible Waived | 40% Coinsurance | 30 Maximum days per calendar year; Preauthorization is required. If you don’t get preauthorization, benefits could be reduced by $250 of the total cost of the service. |

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| **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)** |
|  | Durable medical equipment | No charge | 40% 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 $250 per occurrence. |
| Hospice service | No charge; Deductible Waived | No charge; Deductible Waived | None |
| **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:

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| **Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)** | | |
| * Acupuncture | * Infertility treatment | * Routine eye care (Adult) |
| * Bariatric surgery | * Long-term care | * Routine foot care |
| * Cosmetic surgery | * Non-emergency care when traveling outside the U.S. | * Weight loss programs |
| * Dental care (Adult) | * Private-duty nursing |  |

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| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)** | |
| * Chiropractic care | * Hearing aids (when due to illness/injury) |

**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.](http://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](http://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](http://www.healthcare.gov/) and [http://cciio.cms.gov/programs/consumer/capgrants/index.html.](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.

***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.

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| **Total Example Cost** | **$2,800** |

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| *Cost Sharing* | |
| Deductibles\* | $200 |
| Copayments | $100 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $4,300 |
| **The total Joe would pay is** | **$4,600** |

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| *Cost Sharing* | |
| Deductibles\* | $300 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $10 |
| **The total Mia would pay is** | **$710** |

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| **Peg is Having a Baby**  (9 months of in-network pre-natal care and a hospital delivery)   * **The plan's overall deductible $1,500** * **Specialist copayment $25** * **Hospital (facility) copayment $250** * **Other coinsurance 0%**   **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 $1,500  Copayments $50  Coinsurance $0  *What isn’t covered*  Limits or exclusions $70  **The total Peg would pay is $1,620** | **Managing Joe’s type 2 Diabetes**  (a year of routine in-network care of a well- controlled condition) | **Mia’s Simple Fracture**  (in-network emergency room visit and follow up care) |
| * **The plan's overall deductible $1,500** * **Specialist copayment $25** * **Hospital (facility) copayment $250** * **Other coinsurance 0%** | * **The plan's overall deductible $1,500** * **Specialist copayment $25** * **Hospital (facility) copayment $250** * **Other coinsurance 0%** |
| **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)* | **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 $5,600** |  |
| **In this example, Joe would pay:** | **In this example, Mia would pay:** |
| 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](http://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. | | |