# UMR: TEACHERS HEALTH TRUST: 7670-06-414892 010 011 012 Advantage



**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 1-855-858-6860. 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 1-855-858-6860 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,650** person / **$3,300** family Health Investment Plan Offering (HIPO) (Tier 1), In-Area UHC SHO (Tier 2) & Out-of-Network (Tier 3) | 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, 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 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?** | **$10,600** person / **$21,200** family Health Investment Plan Offering (HIPO) (Tier 1), In-Area UHC SHO (Tier 2) & Out-of-Network (Tier 3) | This plan has an embedded annual out of pocket maximum that means that if you have family coverage, any combination of Covered Family Members may help meet the Family Out of Pocket Maximum; However, no one person will pay more than his or her Embedded Individual Out of Pocket Maximum Amount. |
| **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 1-855-858-6860 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 |
|---|---|---|---|---|---|
| | | HIPO (Tier 1) | In-Area (Tier 2) | Out-of-Network (Tier 3) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | No charge; Deductible Waived | 20% Coinsurance | Not covered | Questions regarding $0-copay/$0-coinsurance providers, visit ththealth.org/health-investment |
| | Specialist visit | $30 Copay per visit; Deductible Waived | 20% Coinsurance | Not covered | Questions regarding $0-copay/$0-coinsurance providers, visit ththealth.org/health-investment |
| | Preventive care/screening/ immunization | No charge; Deductible Waived | 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. |
| | Menopause Health and Wellness Program | $500 copay | Not covered | Not covered | Service must be performed by Dr. Michelle Lin (My Family Doc)<br>(702) 209-3590<br>3227 East Warm Springs Road, Building 23, Ste. 300<br>Las Vegas, Nevada 89120 |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | HIPO (Tier 1) | In-Area (Tier 2) | Out-of-Network (Tier 3) | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge: Deductible Waived if the Steinberg Diagnostics Imaging Lab or a freestanding Quest Diagnostic Lab provides the service | No charge: Deductible Waived if the Steinberg Diagnostics Imaging Lab or a freestanding Quest Diagnostic Lab provides the service | Not covered | Services not performed at a Quest Diagnostics freestanding lab will be covered at 100% after deductible.<br><br>Services not performed at a Steinberg Diagnostics Medical Imaging Lab will be subject to 20% coinsurance after deductible has been met |
| | Imaging (CT/PET scans, MRIs) | No charge: Deductible waived if Steinberg Diagnostics is used. 20% Coinsurance after deductible if services are not available at Steinberg Diagnostics and are performed at other facilities | No charge: Deductible waived if Steinberg Diagnostics is used. 20% Coinsurance after deductible if services are not available at Steinberg Diagnostics and are performed at other facilities | Not covered | None |
| **If you need drugs to treat your illness or condition.**<br><br>More information about prescription drug coverage is available at www.cerpassrx.com/ththealth. | Generic drugs (Tier 1) | Retail: Up to $15 Copay (1–34-day supply); $40 Copay (35–90-day supply)<br>Mail Order: 25% coinsurance to a maximum of $500 | | Not covered | -Prescriptions filled at pharmacies other than THT's Exclusive Network Retail Pharmacies will incur a $25 for Tier 1, $32 for Tier 2, $36 for Tier 3, per prescription choice fee in addition to applicable copays. The pharmacy choice fee does not accumulate toward your out-of-pocket maximum.<br>-If the generic cost of the medication is less than the copay, the individual will be responsible for that lesser amount.<br>Diabetic Supplies: includes syringes needles, lancets, and test strips – limited to a quantity of 200 per 30-day supply. |
| | Preferred brand drugs (Tier 2) | Retail 25% coinsurance to a maximum of $100 (1–34-day supply); 25% coinsurance to a maximum of $300 (35–90-day supply)<br>Mail Order: 25% coinsurance to a maximum of $500 | | Not covered | |
| | Non-preferred brand drugs (Out-of-Network (Tier 3)) | Retail: 40% coinsurance (1–34-day supply)<br>40% coinsurance (35–90-day supply)<br>Mail Order: 40% coinsurance | | Not covered | |
| | Formulary Diabetic Supplies and Insulin | Supplies: $0 Copay<br>Insulin 25% coinsurance to a maximum of:<br>25% coinsurance to maximum of $20 (1–30-day supply) | | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | HIPO (Tier 1) | In-Area (Tier 2) | Out-of-Network (Tier 3) | |
| | | 25% coinsurance to maximum of $40 (31–60-day supply)<br>25% coinsurance to maximum of $60 (61–90-day supply) | | | |
| | Generic asthma drugs (Tier 1) | $15 Copay (1–30-day supply)<br>$40 Copay (31–90-day supply) | | Not covered | -Prescriptions filled at pharmacies other than THT's Exclusive Network Retail Pharmacies will incur a $25 for Tier 1, $32 for Tier 2, $36 for Tier 3, per prescription choice fee in addition to applicable copays. The pharmacy choice fee does not accumulate toward your out-of-pocket maximum.<br>-If the generic cost of the medication is less than the copay, the individual will be responsible for that lesser amount.<br>Diabetic Supplies: includes syringes needles, lancets, and test strips – limited to a quantity of 200 per 30-day supply. |
| | Preferred brand asthma drugs (Tier 2) | 25% coinsurance to a maximum of $50 (1–30-day supply)<br>25% coinsurance to a maximum of $100 (31–60-day supply)<br>25% coinsurance to a maximum of $150 (61–90-day supply) | | Not covered | |
| | Non-preferred brand asthma drugs (Out-of-Network (Tier 3)) | 40% coinsurance up to 90-day supply | | Not covered | |
| | Specialty drugs (Tier 4 and 5) | Generic & Preferred brand drugs: 25% coinsurance to a maximum of $500.<br>Non-Preferred brand: 40% coinsurance | | Not covered | 30-day supply maximum.<br>Questions regarding specialty drugs visit https://www.ththealth.org/pharmacy |
| | Select compounded hormone replacement drugs for the Menopause Health and Wellness Program | 20% coinsurance | | Not covered | Must be prescribed by Dr. Michelle Lin (My Family Doc). (702) 209-3590<br>Prescription must be filled at Solutions Specialty Pharmacy located at 8579 S. Eastern Ave, Las Vegas, NV 89123 (702) 792-3777 |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | HIPO (Tier 1) | In-Area (Tier 2) | Out-of-Network (Tier 3) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not covered | 20% Coinsurance | Not covered | None |
| | Physician/surgeon fees | Not covered | 20% Coinsurance | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | Not covered | $300 Copay for 1st visit; $750 Copay all subsequent visits per plan year facility; 20% Coinsurance physician | $300 Copay for 1st visit; $750 Copay all subsequent visits per plan year facility; 20% Coinsurance physician | Copay may be waived if admitted |
| | Emergency medical transportation | Not covered | 20% Coinsurance | 20% Coinsurance | Ground ambulance allowable expense is the lesser of (i) billed charges or (ii) applicable state or municipal franchisee rate. Preauthorization is required for non-emergency. |
| | Urgent care | No charge; Deductible Waived | $30 Copay per visit; Deductible Waived | $30 Copay per visit; Deductible Waived | Questions regarding $0-copay/$0-coinsurance providers, visit ththealth.org/health-investment |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not covered | 20% Coinsurance | Not covered | Preauthorization is required. |
| | Physician/surgeon fee | Not covered | 20% Coinsurance | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | HIPO (Tier 1) | In-Area (Tier 2) | Out-of-Network (Tier 3) | |
| **If you have mental health, behavioral health, or Substance Abuse services** | Outpatient services | No charge; Deductible Waived | $10 Copay per visit; Deductible Waived Office visits; 20% Coinsurance other outpatient services | Not covered | Questions regarding $0-copay/$0-coinsurance providers, visit ththealth.org/health-investment |
| | Inpatient services | Not covered | 20% Coinsurance | Not covered | Preauthorization is required. |
| **If you are pregnant** | Office visits | No charge; Deductible Waived | No charge; Deductible Waived | Not covered | 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 | 20% Coinsurance | Not covered | |
| | Childbirth/delivery facility services | 20% Coinsurance | 20% Coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 20% Coinsurance | 20% Coinsurance | Not covered | 60 Maximum visits per plan year |
| | Rehabilitation services | No charge; Deductible Waived (Physical Therapies) | $10 Copay per visit (Physical, Occupational and Speech Therapies) | Not covered | Questions regarding $0-copay/$0-coinsurance providers, visit ththealth.org/health-investment |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | HIPO (Tier 1) | In-Area (Tier 2) | Out-of-Network (Tier 3) | |
| | Habilitation services | Not covered | $10 Copay per visit | Not covered | Preauthorization is required after 30 visits. Habilitation services for Learning Disabilities are not covered. Habilitation services for Learning Disabilities are not covered. |
| | Skilled nursing care | Not covered | 20% Coinsurance | Not covered | 60 Maximum days per plan year; Preauthorization is required. |
| | Durable medical equipment | 20% Coinsurance | 20% Coinsurance | Not covered | Preauthorization is required for DME charges in excess of $3,000 for rentals or purchases. |
| | Hospice service | Not covered | 20% Coinsurance | Not covered | None |
| **If your child needs eye care**<br>More information regarding vision coverage can be found at **vsp.com** or by calling **800-877-7195** | Children's eye exam | Not covered | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | Not covered | None |
| **If your child needs dental care**<br>More information regarding dental coverage can be found at **mycigna.com** or by calling **800-244-6224** | Children's dental check-up | Not covered | 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.) | | |
|---|---|---|
| • Infertility treatment | • Long-term care | • Routine eye care (Adult) |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Dental care (Adult) | • Private-duty nursing | • Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture | • Chiropractic care | • Hearing aids |
| • Bariatric surgery | • | • |

**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**
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.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$1,650** |
| **Specialist coinsurance** | **20%** |
| **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** | **$12,850** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,650 |
| Copayments | $0 |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Peg would pay is** | **$3,720** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,650** |
| **Specialist coinsurance** | **20%** |
| **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** | **$5,750** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,650 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $4,300 |
| **The total Joe would pay is** | **$5,550** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,650** |
| **Specialist coinsurance** | **20%** |
| **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** | **$2,950** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,650 |
| Copayments | $0 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Mia would pay is** | **$1,960** |

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 1-855-858-6860.
*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.