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, contact the Archdiocese at 317-236-1594. 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.healthcare.gov/glossary/ or call 317-236-1594 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $2,500 individual / $5,000 family; for non-network providers $5,000 individual / $10,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, 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 is 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.
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?	For network providers $5,000 individual / $10,000 family; for non-network providers $10,000 individual / $20,000 family.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Non-network unrelated donor searches for bone marrow/stem cell transplants, 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 1-800-207-3172 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 the 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
		Network Provider (You will pay the least)	Non-Network Provider (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% coinsurance	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	30% coinsurance	50% coinsurance	
	Preventive care/screening/ immunization	No charge	50% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 1-800-207-3172	Generic drugs	30% coinsurance	50% coinsurance	Coinsurance applies for both retail and mail service. You can receive up to a 90 day supply (30 day supply for specialty drugs) at either a retail pharmacy or through mail service. Mail service must be through the pharmacy benefit manager's mail service program. Fertility drugs are covered up to $1,000 per year. This plan does not cover birth control. Certain prescription drugs may need to be preauthorized.
	Preferred brand drugs	30% coinsurance	50% coinsurance	
	Non-preferred brand drugs	30% coinsurance	50% coinsurance	
	Specialty drugs	30% coinsurance	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	None. In-network deductible applies.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Air ambulance services for non-emergency hospital-to-hospital transfers must be preauthorized. Group ambulance services for non-emergency transfers (other than transfers

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				from one acute facility to another) must be preauthorized. In-network deductible applies.
	Urgent care	30% coinsurance	30% coinsurance	None. In-network deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Services may need to be preauthorized.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	None. Certain services may need to be preauthorized.
	Inpatient services	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	90 visit limit per year, combined network and non-network. Services may need to be preauthorized.
	Rehabilitation services	30% coinsurance	50% coinsurance	25 visit limit for each of physical, occupational, and speech therapy per year when services are rendered as physician services or outpatient services, combined network and non-network. When services are rendered in the home, home healthcare limits apply. 12 visit limit for manipulation therapy per year, combined network and non-network. 60 days limit for physical medicine and rehabilitation (including day rehabilitation therapy services on an outpatient basis) per year, combined network and non-network.
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	90 days limit per year, combined network and non-network.
	Durable medical equipment	30% coinsurance	50% coinsurance	1 wig limit per year after cancer treatment, combined network and non-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				Equipment may need to be preauthorized.
	Hospice services	30% coinsurance	30% coinsurance	None. In-network deductible applies.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 eye exam per year.
	Children's glasses	Not covered	Not covered	None.
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion
- Acupuncture
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Routine foot care

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

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See www.umr.com.
- One in-network routine eye exam per year
- Up to $1,000 per year in prescription drugs to treat infertility
- Private-duty nursing
- Up to $1,000 per year for prescription weight loss drugs

Your Rights to Continue Coverage: You may be eligible to continue your coverage after it ends. Contact Andrea Wunnenberg at 317-236-1533 for more information. 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. For more information about your rights, this notice, or assistance, contact UMR at 1-800-207-3172.

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 Standards? 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	$2,500
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$2,500
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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

The plan's overall deductible	$2,500
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$2,500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$4,050**

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

The plan's overall deductible	$2,500
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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