UMR: DUKE UNIVERSITY: 7670-00-140114 001 002 004

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 or by calling 1-866-318-3853. 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 1-866-318-3853 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** person / **$0** family In-network **$650** person / **$1,950** 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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes; $100 per person for retail brand prescription drugs.	You must pay all of the costs for 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?	**$0** person / **$0** family In-network **$4,000** person / **$12,000** 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, the overall family out-of-pocket limit must be met.
What is not included in the out–of–pocket limit?	Copayments for medical services, penalties, deductibles, 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 1-866-318-3853 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	30% Coinsurance	None
	Specialist visit	$55 Copay per visit	30% Coinsurance	None
	Preventive care/screening/ immunization	$20 Copay per visit PCP; $55 Copay per visit Specialist; Preventive care & Immunizations; No charge Preventive screenings	30% Coinsurance Preventive care & screening; Not covered Immunizations	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	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge Office setting; $150 Copay per occurrence Outpatient setting	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 need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.express-scripts.com.	Generic drugs (Tier 1)	Retail (Up to 31 day supply): $15 copayment; Mail Order (Up to 90 day supply): $25 copayment	Your reimbursement will be the contracted rate less the copayment. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $15 or cost minimum and $30 maximum. Step therapy and/or preauthorization may apply.
	Preferred brand drugs (Tier 2)	Retail (Up to 31 day supply): $50 copayment after $100 brand deductible; Mail Order (Up to 90 day supply): $130 copayment	Your reimbursement will be the contracted rate less the copayment. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $70 minimum and $165 maximum. No deductible for Duke pharmacies for 90 day supply. Step therapy and/or preauthorization may apply.
	Non-preferred brand drugs (Tier 3)	Retail (Up to 31 day supply): $70 copayment after $100 brand deductible; Mail Order Up to 90 day supply): $180 copayment	Your reimbursement will be the contracted rate less the copayment. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $85 minimum and $180 maximum. No deductible for Duke pharmacies for 90 day supply. Step therapy and/or preauthorization may apply.
	Specialty drugs (Tier 4)	Same as above for generic and brand.	Same as above for generic and brand.	Prior authorization required for some specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 Copay per visit	30% Coinsurance	None
	Physician/surgeon fees	$250 Copay per visit	30% Coinsurance	None
If you need immediate medical attention	Emergency room care	$250 Copay per visit	$250 Copay per visit; Deductible Waived	Copay may be waived if admitted
	Emergency medical transportation	No charge	No charge	In-network deductible applies to Out-of-network benefits

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)	
	Urgent care	$35 Copay per visit	30% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$600 Copay per admission for Duke owned hospitals; $700 Copay per admission for all other hospitals	30% Coinsurance for Duke owned hospitals; $900 Copay per admission for all other hospitals	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service.
	Physician/surgeon fee	No charge	30% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$20 Copay per Office visit	30% Coinsurance	Preauthorization is required for hypnosis, psychological testing & electroshock therapy. If you don't get preauthorization, benefits could be reduced by 10% of the total cost of the service.
	Inpatient services	$600 Copay per admission for Duke owned hospitals; $700 Copay per admission for all other hospitals; No charge physicians	30% Coinsurance for Duke owned hospitals; $900 Copay per admission for all other hospitals; 30% Coinsurance physicians	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service.
If you are pregnant	Office visits	$20 copay primary care; $55 copay specialist	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
	Childbirth/delivery professional services	No charge	30% 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)	
	Childbirth/delivery facility services	$600 Copay per admission for Duke owned hospitals; $700 Copay per admission for all other hospitals	30% Coinsurance for Duke owned hospitals; $900 Copay per admission for all other hospitals	Include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	No charge	No charge	100 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service.
	Rehabilitation services	$20 Copay per visit	30% Coinsurance	40 Maximum visits per calendar year OT/PT; 20 Maximum visits per calendar year ST; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service. Habilitation services for learning disabilities are not covered, please refer to your plan document.
	Habilitation services	$20 Copay per visit	30% Coinsurance	
	Skilled nursing care	$250 Copay per admission	$250 Copay per admission	60 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service.
	Durable medical equipment	10% Coinsurance	10% 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 100% per occurrence.
	Hospice service	No charge	No charge	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 your child needs dental or eye care	Children's eye exam	$55 Copay per visit	Not covered	1 Maximum exam per calendar year
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- 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.)

- Chiropractic care
- Hearing aids (to age 19 only)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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 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?

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?
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** **$0**
- **Specialist copayment** **$55**
- **Hospital (facility) copayment** **$600**
- **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	$0
Copayments	$655
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$725**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$55**
- **Hospital (facility) copayment** **$600**
- **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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,500**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$55**
- **Hospital (facility) copayment** **$600**
- **Other coinsurance** **0%**

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*	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$410**

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 1-866-318-3853.
*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.