UMR: TUCSON UNIFIED SCHOOL DISTRICT: 7670-00-414496 001

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 1-800-826-9781. 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 or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$750 person / $1,500 family In-network $5,000 person / $10,000 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 d28 0.705 9.35 a(]TJ 0 Tc[5 rg 26[(c)144ov)4 (er)7 t 5 4. 369.12 381.8

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	

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.caremark.com.	Generic drugs (Tier 1)	$0 Copay	Not Covered	SPECIALTY DRUGS Plan Participants must enroll in the PrudentRx drug advocacy Program or you will be responsible for 30% of the cost of the prescription.
	Preferred brand drugs (Tier 2)	$40 Copay	Not Covered	
	Non-preferred brand drugs (Tier 3)	$80 Copay	Not Covered	
	Specialty drugs (Tier 4)	$0 Copay if participating in Prudent Rx program; otherwise 30% Coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	Not covered ambulatory surgery centers (eff 3/1/2022); 50% Coinsurance all other facilities	None
	Physician/surgeon fees	10% Coinsurance	Not covered ambulatory surgery centers; 50% Coinsurance all other physicians/surgeons	None
	Emergency room care	$500 Copay per visit; Deductible Waived	$500 Copay per visit; Deductible Waived	Copay may be waived if admitted
If you need immediate medical attention	Emergency medical transportation	10% Coinsurance		

	Urgent care	$50 Copay per visit; Deductible Waived	50% 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 have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $200 of the total cost of the service.
	Physician/surgeon fee	10% Coinsurance	50% Coinsurance	
If you have mental health, behavioral health, or substance abuse needs				

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)	

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	$750
„ Specialist copayment	$45

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

„ The plan's overall deductible	$750
„ Specialist copayment	

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

„ The plan's overall deductible	$750

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