etrailer Corporation

$1,000 PPO Summary of Benefits

January 1, 2025

Medical Benefits

Covered Services	In-Network Providers	Non-Network Providers
Calendar Year Deductible		
Per Person	$1,000	$3,000
Family	$2,000	$6,000
Maximum Out-of-Pocket Expense Per Calendar Year		
Per Person	$4,000	$8,000
Family	$8,000	$16,000
Primary Care Physician Office Visits	100% after $30 co-pay	40% after deductible
Specialist Office Visits	100% after $60 co-pay	40% after deductible
Physician Office Services	20% after deductible	40% after deductible
Urgent Care Visit	100% after $75 co-pay	40% after deductible
Emergency Room	20% after in-network deductible	
Ambulance	20% after in-network deductible	
Durable Medical Equipment	20% after deductible	40% after deductible
Outpatient Diagnostic X-ray and Lab	20% after deductible	40% after deductible
Outpatient Hospital Services	20% after deductible	40% after deductible
Inpatient Hospital Services	20% after deductible	40% after deductible
Physical Therapy	100% after $30 co-pay	40% after deductible
Speech, Hearing Occupational Therapy	100% after $30 co-pay	40% after deductible
Preventive/Routine Exams	100%; deductible waived	40% after deductible
Immunizations	100%; deductible waived	40% after deductible
Preventive/Routine Diagnostic Lab and X-Rays	100%; deductible waived	40% after deductible
Mammograms	100%; deductible waived	40% after deductible
Preventive/Routine Pap Test	100%; deductible waived	40% after deductible
Preventive/Routine PSA and Prostate	100%; deductible waived	40% after deductible
Preventive/Routine Colonoscopy, Sigmoidoscopy and Other Similar Procedures	100%; deductible waived	40% after deductible
Preventive/Routine Hearing Exams	100%; deductible waived	40% after deductible
Women's Preventive Health Care	100%; deductible waived	40% after deductible
Prescription Drug Benefits	**In-Network Providers**	**Non-Network Providers**
Retail Pharmacy– Participating Pharmacy		
Co-Pay Per Prescription (30-day supply)		
For Generic Drugs	$10 copay/$30 copay	Reimbursed at the SmithRx Calculated Rate, minus applicable copay, deductible does not apply.
For Preferred Brand Drugs	$40 copay/$120 copay	
For Non-Preferred Brand Drugs	$75 copay/$225 copay	

Mail Order (if applicable) Co-Pay Per Prescription (90-day supply)		
For Generic Drugs	$25 copay	Reimbursed at the SmithRx Calculated Rate, minus applicable copay, deductible does not apply.
For Preferred Brand Drugs	$100 copay	
For Non-Preferred Brand Drugs	$188 copay	
Specialty Drugs Retail: up to a 90-day supply Mail order: up to a 90 day supply Specialty medications: up to a 30-day supply	Preferred specialty drugs 30-day supply: $75.00 copay, deductible does not apply	Not Covered

You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by SmithRx.

Certain drugs may have a preauthorization requirement or may result in a higher cost.

Dispense as written (DAW) provision applies

More information about prescription drug coverage is available at www.mysmithrx.com.

UMR Customer Service: 1-800-826-9781 www.umr.com
Submit Claims to: UMR P.O. Box 30541 Salt Lake City, UT 84130-0541

This is a summary of benefits and not a guarantee. Benefit payments are subject to all plan provisions and eligibility requirements at the time services are rendered. The plan document and summary plan description are the official sources of information. In the event of a discrepancy, the plan document and summary plan description will prevail.

UMR
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