



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.umar.com](http://www.umar.com) or by calling 1-800-207-3172. 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.umar.com](http://www.umar.com) or call 1-800-207-3172 to request a copy.

Important Questions	Answers	Why this Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p>\$1,000 person / \$2,000 family In-network \$2,000 person / \$4,000 family Out-of-network</p>	<p>Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible amount</a> before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>\$4,000 person / \$8,000 family In-network \$8,000 person / \$16,000 family Out-of-network</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p>Penalties, <a href="#">premiums</a>, <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://www.umar.com">www.umar.com</a> or call 1-800-207-3172 for a list of <a href="#">network providers</a>.</p>	<p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>



All copayment costs shown in this chart are applied before the deductible; coinsurance costs are applied after your deductible has been met, as applicable.

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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 Copay per visit, Deductible Waived	30% Coinsurance	None
	<u>Specialist</u> visit	\$25 Copay per visit, Deductible Waived	30% Coinsurance	None
	<u>Preventive care/screening/immunization</u>	No charge, Deductible Waived	30% Coinsurance for Preventive care & screening, No charge, Deductible Waived for Immunizations	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check for what your plan will pay.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$25 Copay per visit; Deductible Waived for office setting, No charge for outpatient setting	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	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)	
<b>If you need drugs to treat your illness or condition.</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs (Tier 1)	\$10 for a 30 day supply, retail; \$30 for a 31-90 day supply, retail; \$20 for up to a 90 day supply, mail order	\$10 for a 30 day supply, retail; \$30 for a 31-90 day supply, retail; \$20 for up to a 90 day supply, mail order	Deductible waived.  Covered prescription drugs on the Value Priced Drug List have no copay.  *Specialty prescriptions can only be obtained through CVS Pharmacy or CVS Caremark mail order to a maximum 30 day supply.
	Preferred brand drugs (Tier 2)	\$30 for a 30 day supply, retail; \$90 for a 31-90 day supply, retail; \$60 for up to a 90 day supply, mail order	\$25 for a 30 day supply, retail; \$75 for a 31-90 day supply, retail; \$50 for up to a 90 day supply, mail order	
	Non-preferred brand drugs (Tier 3)	\$60 for a 30 day supply, retail; \$180 for a 31-90 day supply, retail; \$120 for up to a 90 day supply, mail order	\$50 for a 30 day supply, retail; \$150 for a 31-90 day supply, retail; \$100 for up to a 90 day supply, mail order	
	<a href="#">Specialty drugs</a> (Tier 4)	25% TO \$250 MAX	25% TO \$250 MAX	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	30% Coinsurance	None
	Physician/surgeon fees	No charge	30% Coinsurance	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 Copay per visit, Deductible Waived	\$250 Copay per visit, Deductible Waived	Copay may be waived if admitted
	<a href="#">Emergency medical transportation</a>	No charge	No charge	In-network deductible applies to Out-of-network benefits; \$25,000 Maximum benefit per occurrence air ambulance
	<a href="#">Urgent care</a>	\$100 Copay per visit, Deductible Waived	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 have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to \$250 of the total cost of the service Out-of-network.
	Physician/surgeon fee	No charge	30% Coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$25 Copay per visit, Deductible Waived for office visits; No charge for other outpatient services	30% Coinsurance	None
	Inpatient services	No charge	30% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to \$250 of the total cost of the service Out-of-network.
If you are pregnant	Office visits	No charge, Deductible Waived	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 include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	30% Coinsurance	
	Childbirth/delivery facility 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)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	30% Coinsurance	100 Maximum visits per plan year
	<a href="#">Rehabilitation services</a>	\$25 Copay per visit, Deductible Waived	30% Coinsurance	60 Maximum visits per plan year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to \$250 of the total cost of the service Out-of-network. If your plan excludes Learning Disabilities, habilitation services for learning disabilities are not covered, please refer to your plan document.
	<a href="#">Habilitation services</a>	\$25 Copay per visit, Deductible Waived	30% Coinsurance	
	<a href="#">Skilled nursing care</a>	No charge	30% Coinsurance	30 Maximum days per confinement; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to \$250 of the total cost of the service Out-of-network.
	<a href="#">Durable medical equipment</a>	No charge	30% Coinsurance	Preauthorization is required for DME in excess of \$1,000 for rentals or for purchases. If you don't get preauthorization, benefits could be reduced by 25% up to \$250 per occurrence Out-of-network.
	<a href="#">Hospice service</a>	No charge	30% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge, Deductible Waived	No charge, Deductible Waived	None
	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 18)
- 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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 on how 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](http://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](#).

***This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.***

***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](#) **\$1,000**
- [Specialist copayment](#) **\$25**
- Hospital (facility) [coinsurance](#) **0%**
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$1,270</b>

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

- The [plan's](#) overall [deductible](#) **\$1,000**
- [Specialist copayment](#) **\$25**
- Hospital (facility) [coinsurance](#) **0%**
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$200
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$420</b>

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

- The [plan's](#) overall [deductible](#) **\$1,000**
- [Specialist copayment](#) **\$25**
- Hospital (facility) [coinsurance](#) **0%**
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$1,000
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$1,410</b>