



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 1-800-826-9781. 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.umar.com](http://www.umar.com) or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	<b>\$4,000</b> person / <b>\$8,000</b> family In-network <b>\$12,000</b> person / <b>\$24,000</b> family Out-of-network	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<b>\$4,000</b> person / <b>\$8,000</b> family In-network <b>\$14,500</b> person / <b>\$29,000</b> family Out-of-network	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Penalties, <u>premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.umar.com">www.umar.com</a> or call 1-800-826-9781 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (a <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No charge	30% Coinsurance	None
	<u>Specialist visit</u>	No charge	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 what your plan will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge	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)	No charge, maximum 90 day supply, retail or mail order	No charge, maximum 90 day supply, retail or mail order	In-network deductible applies to Out-of-network retail pharmacies.  Covered prescriptions on the HSA Preventive Generics Therapy Drug List are no charge.  Covered diabetic test strips, lancets and insulin needles are no charge.  *Note: 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)	No charge, maximum 90 day supply, retail or mail order	No charge, maximum 90 day supply, retail or mail order	
	Non-preferred brand drugs (Tier 3)	No charge, maximum 90 day supply, retail or mail order	No charge, maximum 90 day supply, retail or mail order	
	<u>Specialty drugs</u> (Tier 4)	No charge, maximum 30 day supply*	No charge, maximum 30 day supply*	
<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>	<u>Emergency room care</u>	No charge	No charge	In-network deductible applies to Out-of-network benefits
	<u>Emergency medical transportation</u>	No charge	No charge	In-network deductible applies to Out-of-network benefits
	<u>Urgent care</u>	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)	
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	No charge	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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	30% Coinsurance	None
	<u>Rehabilitation services</u>	No charge	30% Coinsurance	None
	<u>Habilitation services</u>	Not covered	Not covered	None
	<u>Skilled nursing care</u>	No charge	30% Coinsurance	60 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.
	<u>Durable medical equipment</u>	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.
	<u>Hospice service</u>	No charge	30% Coinsurance	None
<b>If your child needs dental or eye care</b>	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       | • Dental care (adult)   | • Routine foot care    |
| • Bariatric surgery | • Infertility treatment | • Weight loss programs |
| • Cosmetic surgery  | • Long-term care        |                        |

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

- |                            |                                                      |                            |
|----------------------------|------------------------------------------------------|----------------------------|
| • Chiropractic care        | • Non-emergency care when traveling outside the U.S. | • Routine eye care (adult) |
| • Hearing aids (to age 18) | • Private-duty nursing (Outpatient care)             |                            |

**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 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**

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 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 page.—————

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 **\$4,000**
- Specialist coinsurance **0%**
- Hospital (facility) coinsurance **0%**
- Other coinsurance **0%**

**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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
---------------------------	-----------------

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$4,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$4,100</b>

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

- The plan's overall deductible **\$4,000**
- Specialist coinsurance **0%**
- 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>\$7,400</b>
---------------------------	----------------

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$1,200
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,220</b>

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

- The plan's overall deductible **\$4,000**
- Specialist coinsurance **0%**
- 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>\$1,900</b>
---------------------------	----------------

**In this example, Mia would pay:**

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