



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 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 or call 1-800-207-3172 to request a copy.

Important Questions	Answers	Why this Matters:
<p>What is the overall deductible?</p>	<p>\$1,250 person / \$2,500 family In-network \$2,500 person / \$5,000 family Out-of-network</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care services are covered before you meet your deductible.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>\$3,250 person / \$6,500 family In-network \$5,250 person / \$10,500 family Out-of-network</p>	<p>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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Penalties, premiums, balance billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.umar.com or call 1-800-207-3172 for a list of network providers.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</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 provider's office or clinic	Primary care visit to treat an injury or illness	\$35 Copay per visit. 10% Coinsurance	\$70 Copay per visit. 30% Coinsurance	None
	Specialist visit	\$70 Copay per visit. 10% Coinsurance	\$140 Copay per visit. 30% Coinsurance	None
	Preventive care/screening/immunization	No charge. Deductible Waived	\$70 Copay per visit PCP. \$140 Copay per visit Specialist. No charge. Deductible Waived for Immunizations. 30% Coinsurance for Preventive care & screening.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% Coinsurance Office setting; \$100 Copay per day. 10% Coinsurance Outpatient setting	30% Coinsurance Office setting; \$200 Copay per day. 30% Coinsurance Outpatient setting	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)	
<p>If you need drugs to treat your illness or condition.</p> <p>More information about prescription drug coverage is available at www.caremark.com</p>	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.	<p>Deductible waived.</p> <p>Covered prescriptions on the Value Priced Generic Drug List have no copay.</p> <p>If you choose a non-preferred drug when a generic is available, you will pay the cost difference between the two plus the non-preferred copay. However, if your physician indicates dispense as written (DAW) on prescription, then only the non-preferred copay will apply.</p> <p>Separate prescription drug out of pocket maximum: \$2,000 person / \$4,000 family. <i>This is in addition to the medical maximum out-of-pocket shown on page 1.</i></p> <p>*Specialty prescriptions can only be obtained through a CVS Pharmacy or by CVS Caremark mail order to a maximum 30-day supply.</p>
	Preferred brand drugs (Tier 2)	\$40 for a 30-day supply, retail; \$120 for a 31–90-day supply, retail; \$80 for up to a 90-day supply, mail order.	\$40 for a 30-day supply, retail; \$120 for a 31–90-day supply, retail; \$80 for up to a 90-day supply, mail order.	
	Non-preferred brand drugs (Tier 3)	\$80 for a 30-day supply, retail; \$240 for a 31–90-day supply, retail; \$160 for up to a 90-day supply, mail order.	\$80 for a 30-day supply, retail; \$240 for a 31–90-day supply, retail; \$160 for up to a 90-day supply, mail order.	
	Specialty drugs (Tier 4)	20% to a \$250 maximum for up to a 30-day supply. *	20% to a \$250 maximum for up to a 30-day supply. *	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	30% Coinsurance	None
	Physician/surgeon fees	10% Coinsurance	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 immediate medical attention	Emergency room care	\$250 Copay per visit. 10% Coinsurance	\$250 Copay per visit. 10% Coinsurance	In-network deductible applies to Out-of-network benefits. Copay may be waived if admitted
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	In-network deductible applies to Out-of-network benefits
	Urgent care	\$100 Copay per visit. 10% Coinsurance	\$100 Copay per visit. 10% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	30% Coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 25% up to a \$250 Maximum of the total cost of the service for Out-of-network only.
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	\$35 Copay per visit. 10% Coinsurance office setting; 10% Coinsurance other outpatient services	\$70 Copay per visit. 30% Coinsurance office setting; 30% Coinsurance other outpatient services	None
	Inpatient services	10% Coinsurance	30% Coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 25% up to a \$250 Maximum of the total cost of the service for Out-of-network only.

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 are pregnant	Office visits	No charge. Deductible Waived	30% Coinsurance	Cost sharing does not apply for 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	10% Coinsurance	30% Coinsurance	
	Childbirth/delivery facility services	10% Coinsurance	30% Coinsurance	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	30% Coinsurance	60 Maximum visits per plan year
	Rehabilitation services	\$35 Copay per visit. 10% Coinsurance	\$70 Copay per visit. 30% Coinsurance	20 Maximum visits per plan year OT. 20 Maximum visits per plan year PT. 20 Maximum visits per plan year ST. Preauthorization is required.
	Habilitation services	\$35 Copay per visit. 10% Coinsurance	\$70 Copay per visit. 30% Coinsurance	
	Skilled nursing care	10% Coinsurance	30% Coinsurance	30 Maximum days per confinement; Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 25% up to a \$250 Maximum of the total cost of the service for Out-of-network only.
	Durable medical equipment	10% Coinsurance	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 a \$250 Maximum per occurrence for Out-of-network only.
	Hospice service	10% Coinsurance	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 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 .)		
<ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery	<ul style="list-style-type: none">• Dental care (Adult)• Infertility treatment• Long-term care	<ul style="list-style-type: none">• 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.)		
<ul style="list-style-type: none">• Chiropractic care• Hearing aids	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• 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. 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](#). 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? 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 the 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](#) \$1,250
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,250
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$2,320

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

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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:

<i>Cost Sharing</i>	
Deductibles*	\$900
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,220

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

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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:

<i>Cost Sharing</i>	
Deductibles*	\$1,250
Copayments	\$400
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$1,760