



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:
What is the overall <a href="#">deductible</a> ?	\$2,000 person / \$2,750 person + one / \$3,500 family	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	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>
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$4,000 person / \$5,250 person + one / \$6,500 family In-network \$4,500 person / \$6,000 person + one / \$7,500 family Out-of-network	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Penalties, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	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> .	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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 Copay per visit. 10% Coinsurance	\$50 Copay per visit. 30% Coinsurance	None
	<a href="#">Specialist</a> visit	\$25 Copay per visit. 10% Coinsurance	\$50 Copay per visit. 30% Coinsurance	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; Deductible Waived	\$50 Copay per visit. 30% Coinsurance for Preventive care; 30% Coinsurance for Preventive screening. No charge. Deductible Waived for Immunizations	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% Coinsurance	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	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)	
<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)	\$5 for a 30-day supply, retail; \$15 for a 31–90-day supply, retail; \$5 for up to a 90-day supply, mail order.	\$5 for a 30-day supply, retail; \$15 for a 31–90-day supply, retail; \$5 for up to a 90-day supply, mail order.	Deductible waived.  Covered prescriptions on the Value Priced Generic Drug List have no copay.  There is no copay for covered diabetic test strips, lancets, insulin, or syringes.  Covered insulin copay: \$5  *Specialty prescriptions can only be obtained through a CVS Pharmacy or by CVS Caremark mail order to a maximum 30-day supply.
	Preferred brand drugs (Tier 2)	\$20 for a 30-day supply, retail; \$60 for a 31–90-day supply, retail; \$40 for up to a 90-day supply, mail order.	\$20 for a 30-day supply, retail; \$60 for a 31–90-day supply, retail; \$40 for up to a 90-day supply, mail order.	
	Non-preferred brand drugs (Tier 3)	\$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.	
	<a href="#">Specialty drugs</a> (Tier 4)	Applicable Tier Copay, maximum 30-day supply*.	Applicable Tier Copay, maximum 30-day supply*.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	30% Coinsurance	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service for Out-of-network.
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200 Copay per visit; 10% Coinsurance	\$200 Copay per visit; 10% Coinsurance	In-network deductible applies to Out-of-network benefits; Copay may be waived if admitted
	<a href="#">Emergency medical transportation</a>	10% Coinsurance	10% Coinsurance	In-network deductible applies to Out-of-network benefits
	<a href="#">Urgent care</a>	\$25 Copay per visit; 10% Coinsurance	\$50 Copay per visit; 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)	10% Coinsurance	30% Coinsurance	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service for Out-of-network.
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$25 Copay per visit; 10% Coinsurance office visits; 10% Coinsurance other outpatient services	\$50 Copay per visit; 30% Coinsurance office visits; 30% Coinsurance other outpatient services	None
	Inpatient services	10% Coinsurance	30% Coinsurance	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service for Out-of-network.
If you are pregnant	Office visits	No charge; Deductible Waived	30% Coinsurance	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">deductible</a> , <a href="#">copayment</a> or <a href="#">coinsurance</a> 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	

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>	10% Coinsurance	30% Coinsurance	50 Maximum visits per calendar year; <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service for Out-of-network.
	<a href="#">Rehabilitation services</a>	\$25 Copay per visit; 10% Coinsurance	\$50 Copay per visit; 30% Coinsurance	Preauthorization is required. Habilitation services for Learning Disabilities are not covered.
	<a href="#">Habilitation services</a>	\$25 Copay per visit; 10% Coinsurance	\$50 Copay per visit; 30% Coinsurance	
	<a href="#">Skilled nursing care</a>	10% Coinsurance	30% Coinsurance	60 Maximum days per confinement; <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service for Out-of-network.
	<a href="#">Durable medical equipment</a>	20% Coinsurance	30% Coinsurance	<a href="#">Preauthorization</a> is required for DME in excess of \$1,000 for rentals or for purchases. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 per occurrence for Out-of-network.
	<a href="#">Hospice service</a>	10% Coinsurance	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	No charge; Deductible Waived	No charge; Deductible Waived	1 Maximum pair of lenses per calendar year; 1 Maximum set of frames every 12 months to age 19; \$100 Maximum benefit per calendar year for frames from age 19
	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
- 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.)

- Bariatric surgery (from age 25)
- 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 the complete terms of this plan.***

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-207-3172.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-207-3172.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-207-3172.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-800-207-3172.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-207-3172.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-207-3172.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-207-3172.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-800-207-3172.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$900
What isn't covered	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$2,970</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
<a href="#">Deductibles*</a>	\$1,000
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
What isn't covered	
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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
<a href="#">Deductibles*</a>	\$2,000
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$50
What isn't covered	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$2,360</b>