



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 1-800-826-9781. 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 or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$2,700 person / \$4,050 person + one / \$5,400 family \$2,700 In-network Maximum amount that any one person will satisfy toward the annual family deductible	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 .
Are there services covered before you meet your deductible ?	Yes. Preventive care services are covered before you meet your deductible .	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/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$6,850 person / \$10,275 person + one / \$13,700 family \$6,850 In-network Maximum amount that any one person will satisfy toward the annual family out-of-pocket	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.
What is not included in the out-of-pocket limit ?	Penalties, premiums , balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.umar.com or call 1-800-826-9781 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 (a 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](#) 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
		EPO (You will pay the least)	Non-EPO (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	30% Coinsurance	Not covered	None
	Specialist visit	30% Coinsurance	Not covered	None
	Preventive care/screening/immunization	No charge; Deductible Waived	Not covered	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO (You will pay the least)	Non-EPO (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	Not covered	Preauthorization is required.
<p>If you need drugs to treat your illness or condition.</p> <p>More information about prescription drug coverage is available at</p>	Generic drugs (Tier 1)	<p>Retail 30-day supply: 20% (\$10 min / \$100 max)</p> <p>After 2nd refill for Maintenance: 40% (\$20 min / \$200 max) (when purchased at a Non-referred Pharmacy)</p> <p>Retail 31-90-day supply purchased at Preferred Pharmacy (Kroger/Wal-Mart/CVS/Walgreens): 20% (\$20 min / \$200 max)</p> <p>Mail order 90-day supply: 20% (\$20 min / \$200 max)</p>		No retail grace fill allowed at retail for specialty medications. All fills will be dispensed by Acaria Health.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO (You will pay the least)	Non-EPO (You will pay the most)	
www.OptumRx.com	Preferred brand drugs (Tier 2)	Retail 30-day supply: 25% (\$30 min / \$160 max) After 2nd refill for Maintenance: 50% (\$60 min / \$320 max) (when purchased at a Non-referred Pharmacy) Retail 31-90-day supply purchased at Preferred Pharmacy (Kroger/Wal-Mart/CVS/Walgreens): 25% (\$60 min / \$320 max) Mail order 90-day supply: 25% (\$60 min / \$320 max)		No retail grace fill allowed at retail for specialty medications. All fills will be dispensed by Acaria Health.
	Non-preferred brand drugs (Tier 3)	Retail 30-day supply: 30% (\$75 min / \$225 max) After 2nd refill for Maintenance: 60% (\$150 min / \$450 max) (when purchased at a Non-referred Pharmacy) Retail 31-90-day supply purchased at Preferred Pharmacy (Kroger/Wal-Mart/CVS/Walgreens): 30% (\$150 min / \$450 max) Mail order 90-day supply: 30% (\$150 min / \$450 max)		No retail grace fill allowed at retail for specialty medications. All fills will be dispensed by Acaria Health.
	Specialty drugs (Tier 4)	Specialty medications are covered in the tiers listed above.		
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	Not covered	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO (You will pay the least)	Non-EPO (You will pay the most)	
surgery	Physician/surgeon fees	30% Coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	\$200 Copay per visit; 30% Coinsurance	\$200 Copay per visit; 30% Coinsurance	Copay may be waived if admitted
	Emergency medical transportation	30% Coinsurance	30% Coinsurance	None
	Urgent care	30% Coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	Not covered	Preauthorization is required.
	Physician/surgeon fee	30% Coinsurance	Not covered	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	30% Coinsurance	Not covered	Preauthorization is required for Partial hospitalization.
	Inpatient services	30% Coinsurance	Not covered	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO (You will pay the least)	Non-EPO (You will pay the most)	
If you are pregnant	Office visits	No charge; Deductible Waived	Not covered	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	30% Coinsurance	Not covered	
	Childbirth/delivery facility services	30% Coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	Not covered	Preauthorization is required.
	Rehabilitation services	30% Coinsurance	Not covered	45 Maximum visits per plan year; Preauthorization is required.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	30% Coinsurance	Not covered	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO (You will pay the least)	Non-EPO (You will pay the most)	
	Durable medical equipment	30% Coinsurance	Not covered	Preauthorization is required for DME in excess of \$500 for purchases or for all rentals.
	Hospice service	30% Coinsurance	Not covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	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](#).)

- Cosmetic surgery
- Dental care (Adult)
- Routine eye care (Adult)
- Routine foot care

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

- Acupuncture (EPO only)
- Bariatric surgery (Bariatric Resource Services only)
- Chiropractic care (EPO only)
- Hearing aids (EPO only)
- Infertility treatment (EPO only)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Outpatient care) (EPO only)

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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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](#). For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help you file your [appeal](#). A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform 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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-826-9781.

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](#) \$2,700
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,700
Copayments	\$80
Coinsurance	\$2,700
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$5,480

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

- The [plan's](#) overall [deductible](#) \$2,700
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$1,900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,120

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

- The [plan's](#) overall [deductible](#) \$2,700
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umar.com or call 1-800-826-9781.