




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, see www.umar.com. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-888-309-7348 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Not applicable	This <u>plan</u> does not have a <u>deductible</u> .
Are there other deductibles for specific services?	Yes. <u>Network providers</u> : \$100 /individual for certain outpatient services, \$100 /individual for most inpatient services. <u>Out-of-network providers</u> : \$100 /individual for certain outpatient services, \$100 /individual for most inpatient services. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	<u>Network providers</u> : \$5,000 /individual, \$10,000 /family; <u>Out-of-network providers</u> : No <u>out-of-pocket limit</u> ; <u>Prescription drugs</u> : \$1,600 /individual, \$3,200 /family	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.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> 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> .
Will you pay less if you use a network provider?	Yes. See www.umar.com or call 1-888-309-7348 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 <u>plan's 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 (<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.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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
		Network Provider (You will pay the least)	Out-of-Network Provider (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	\$10 <u>copay</u> per visit	50% <u>coinsurance</u>	None
	<u>Specialist visit</u>	\$10 <u>copay</u> per visit	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> ; inpatient <u>deductible</u> and/or outpatient <u>deductible</u> applies	50% <u>coinsurance</u> ; inpatient <u>deductible</u> and/or outpatient <u>deductible</u> applies	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> ; inpatient <u>deductible</u> and/or outpatient <u>deductible</u> applies	50% <u>coinsurance</u> ; inpatient <u>deductible</u> and/or outpatient <u>deductible</u> applies	\$250 penalty if <u>preauthorization</u> not obtained.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs	\$10 <u>copay</u> per prescription at retail and mail order	\$10 <u>copay</u> per prescription at retail and mail order	Limited to up to a 30-day supply at retail pharmacies. Limited to up to a 90-day supply at Caremark mail order pharmacy and at CVS. If a generic version of a non-preferred brand name drug is available, your cost will be the generic <u>copay</u> plus the price difference between the generic drug and the brand name drug. No charge for FDA-approved generic preventive medications (e.g., generic contraceptives) or brand name preventive medications if a generic is not medically appropriate.
	Preferred brand drugs	\$20 <u>copay</u> per prescription at retail and mail order	\$20 <u>copay</u> per prescription at retail and mail order	
	Non-preferred brand drugs	\$30 <u>copay</u> per prescription at retail and mail order	\$30 <u>copay</u> per prescription at retail and mail order	
	<u>Specialty drugs</u>	Covered as generic, preferred brand, or non-preferred brand drugs, above	Covered as generic, preferred brand, or non-preferred brand drugs, above	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> ; outpatient <u>deductible</u> applies	50% <u>coinsurance</u> ; outpatient <u>deductible</u> applies	\$250 penalty if <u>preauthorization</u> not obtained. <u>Coinurance</u> waived for non-surgical procedures. 0% coinsurance and deductible waived for certain surgeries when using a Lantern Surgery Care provider. Bariatric surgeries must be performed with a Lantern Surgery Care provider for coverage.
	Physician/surgeon fees	20% <u>coinsurance</u> ; outpatient <u>deductible</u> applies	50% <u>coinsurance</u> ; outpatient <u>deductible</u> applies	
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay</u> per visit	\$50 <u>copay</u> per visit	<u>Copay</u> waived if admitted. Professional/physician charges may be billed separately.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> for air ambulance services; 50% <u>coinsurance</u> for all other <u>emergency medical transportation</u>	None
	<u>Urgent care</u>	\$50 <u>copay</u> per visit	\$50 <u>copay</u> per visit	<u>Copay</u> waived if admitted.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> ; inpatient <u>deductible</u> applies	50% <u>coinsurance</u> ; inpatient <u>deductible</u> applies	\$250 penalty if <u>preauthorization</u> not obtained. 0% coinsurance and deductible waived for certain surgeries when using a Lantern Surgery Care provider. Bariatric surgeries must be performed with a Lantern Surgery Care provider for coverage.
	Physician/surgeon fees	20% <u>coinsurance</u> ; inpatient <u>deductible</u> applies	50% <u>coinsurance</u> ; inpatient <u>deductible</u> applies	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <u>copay</u> per office visit; 20% <u>coinsurance</u> for all other outpatient services, outpatient <u>deductible</u> applies	50% <u>coinsurance</u> ; outpatient <u>deductible</u> applies	\$250 penalty if <u>preauthorization</u> of partial <u>hospitalization</u> and intensive outpatient treatment not obtained.
	Inpatient services	20% <u>coinsurance</u> ; inpatient <u>deductible</u> applies	50% <u>coinsurance</u> ; inpatient <u>deductible</u> applies	\$250 penalty if <u>preauthorization</u> not obtained.
If you are pregnant	Office visits	\$10 <u>copay</u> per initial confirmation visit, then 20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Primary care physician</u> or <u>specialist</u> benefit levels apply to initial visit to confirm pregnancy. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copay</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u> ; inpatient <u>deductible</u> applies	50% <u>coinsurance</u> ; inpatient <u>deductible</u> applies	
	Childbirth/delivery facility services	20% <u>coinsurance</u> ; inpatient <u>deductible</u> applies	50% <u>coinsurance</u> ; inpatient <u>deductible</u> applies	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u> ; outpatient <u>deductible</u> applies	50% <u>coinsurance</u> ; outpatient <u>deductible</u> applies	\$250 penalty if <u>preauthorization</u> not obtained. Limited to 60 days per calendar year and 16 hours per day. Limit does not apply to mental health and substance use disorder conditions.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> per visit	50% <u>coinsurance</u> for <u>primary care physician</u> or <u>specialist</u> visit	\$250 penalty if <u>preauthorization</u> not obtained. <u>Rehabilitation services</u> , including cardiac rehabilitation and chiropractic services, are limited to 40 days per calendar year. Limit does not apply to physical, speech, and occupational therapy for mental health conditions.
	<u>Habilitation services</u>	\$10 <u>copay</u> per visit	50% <u>coinsurance</u> for <u>primary care physician</u> or <u>specialist</u> visit	\$250 penalty if <u>preauthorization</u> not obtained. Covered when <u>medically necessary</u> to treat a mental health condition (e.g., autism) or a congenital abnormality.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> ; inpatient <u>deductible</u> applies	50% <u>coinsurance</u> ; inpatient <u>deductible</u> applies	\$250 penalty if <u>preauthorization</u> not obtained. Limited to 90 days per calendar year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> ; outpatient <u>deductible</u> applies	50% <u>coinsurance</u> ; outpatient <u>deductible</u> applies	\$250 penalty if <u>preauthorization</u> not obtained.
	<u>Hospice services</u>	20% <u>coinsurance</u> ; inpatient <u>deductible</u> and/or outpatient <u>deductible</u> applies	50% <u>coinsurance</u> ; inpatient <u>deductible</u> and/or outpatient <u>deductible</u> applies	\$250 penalty if <u>preauthorization</u> not obtained.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	No charge up to \$40 then 100%	Limited to one eye exam per calendar year. Vision benefits are separately administered by Cigna Vision.
	Children's glasses	Frames: No charge up to \$90 then 100%; Lenses: No charge for single vision, bifocal or trifocal lenses	Frames: No charge up to \$45 then 100%; Lenses: No charge up to \$45 then 100% for single vision lenses	Frames limited to one set every two calendar years. Lenses limited to one set every calendar year. Vision benefits are separately administered by Cigna Vision.
	Children's dental check-up	No charge	20% <u>coinsurance</u> , plus <u>balance billing</u>	<u>In-network</u> dental services limited to \$1,500 per person per calendar year. <u>Out-of-network</u> dental services limited to \$1,000 per person per calendar year. Dental benefits are separately administered by Delta Dental.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic surgery Hearing aids 	<ul style="list-style-type: none"> Infertility treatment Long-term care 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Private-duty nursing
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> Bariatric surgery (covered <u>in-network</u> only; surgery limited to \$10,000 per lifetime) Chiropractic care 	<ul style="list-style-type: none"> Dental care (Adult)(limited to \$1,500 per person per year <u>in-network</u> and \$1,000 per person per year <u>out-of-network</u>) Routine eye care (Adult) 	<ul style="list-style-type: none"> Routine foot care (limited to \$1,000 per calendar year)

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: the 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 on how 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: UMR Customer service at 1-888-309-7348. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 Standards? 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 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-244-6224.

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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copay</u>	\$10
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,360
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,830

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copay</u>	\$10
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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>	
<u>Deductibles</u>	\$110
<u>Copayments</u>	\$690
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$800

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copay</u>	\$10
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*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>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$180
<u>Coinsurance</u>	\$190
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$470

The plan would be responsible for the other costs of these EXAMPLE covered services.