




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, call 1-800-527-1647. 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 1-800-826-9781 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p><b>\$500/person, \$1,500/family.</b> (When three family members each meet their individual <a href="#">deductible</a>, the family <a href="#">deductible</a> is met.)</p>	<p>Generally, you must pay all of 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 three family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Network preventive services</a>, <a href="#">network</a> office visits and <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a>.</p>	<p>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>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p><b>\$50/person dental <a href="#">deductible</a>.</b> There are no other specific <a href="#">deductibles</a>.</p>	<p>You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>In-network: <a href="#">coinsurance</a> limit: <b>\$2,500/person, \$4,000/family</b>; <a href="#">out-of-pocket limit</a>: <b>\$6,350/person, \$12,700/family</b>. Out-of-network: <a href="#">coinsurance</a> limit: <b>\$7,500/person, unlimited/family</b>; <a href="#">out-of-pocket limit</a>: <b>unlimited</b>.</p>	<p>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 limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Coinsurance</a> limit: <a href="#">Premium</a>, balance-billed charges, <a href="#">copays</a>, plan <a href="#">deductibles</a>, <a href="#">prescription drugs</a>, dental and vision expenses, <a href="#">preauthorization</a> penalties, and health care this plan doesn't cover. <a href="#">Out-of-pocket limit</a>: <a href="#">Premium</a>, balance-billed charges, dental and vision expenses, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

Important Questions	Answers	Why This Matters:
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 1-800-826-9781 for a list of <a href="#">network providers</a> . For mental health/substance abuse treatment providers, call Mines & Associates at 1-800-873-7138.	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 <a href="#">plan's 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](#) 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /office visit and 20% <a href="#">coinsurance</a> /procedures during office visit; <a href="#">deductible</a> does not apply to office visit	35% <a href="#">coinsurance</a>	<a href="#">Network</a> telehealth visit: \$25 <a href="#">copay</a> /visit.
	<a href="#">Specialist</a> visit	Premium Care Specialist: \$35 <a href="#">copay</a> /visit; Non-Premium Care Specialist: \$45 <a href="#">copay</a> / visit; 20% <a href="#">coinsurance</a> / procedures during office visit; <a href="#">deductible</a> does not apply to office visit.	35% <a href="#">coinsurance</a>	None.
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	35% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. <a href="#">Out-of-network</a> limited to mammograms, pap smears, PSA testing and colonoscopies.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	None.
	Imaging (CT/PET scans, MRIs)	\$75 <a href="#">copay</a> /day, plus 20% <a href="#">coinsurance</a>	\$75 <a href="#">copay</a> /day, plus 35% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required; \$100 benefit reduction if failure to <a href="#">preauthorize</a> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document.

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> will be available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	34-day supply: \$5 <a href="#">copay</a> ; 90-day supply: \$10 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	Not covered	If you receive a brand name drug when a generic drug is available, you will pay the generic drug <a href="#">copay</a> plus the difference in cost between the generic and brand name drug. Some exceptions apply.  Coverage is limited up to a 34-day supply (retail and specialty drugs) or a 90-day supply if prescribed by your Physician; certain drugs may be subject to <a href="#">preauthorization</a> or step therapy; <a href="#">preauthorization</a> is required for specialty drugs.
	Preferred brand drugs	34-day supply: 20% <a href="#">coinsurance</a> up to \$50/prescription; 90-day supply: 20% <a href="#">coinsurance</a> up to \$100/prescription. <a href="#">Deductible</a> does not apply.	Not covered	
	Non-preferred brand drugs	34-day supply: 30% <a href="#">coinsurance</a> up to \$75/prescription; 90-day supply: 30% <a href="#">coinsurance</a> up to \$150/prescription. <a href="#">Deductible</a> does not apply.	Not covered	
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a> up to \$100/prescription. <a href="#">Deductible</a> does not apply.	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. \$100 penalty for failure to <a href="#">preauthorize</a> .
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. \$100 penalty for failure to <a href="#">preauthorize</a> .
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	None.

\* For more information about limitations and exceptions, see the [plan](#) or policy document.

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copay</a> /office visit and 20% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to office visit	35% <a href="#">coinsurance</a>	None.
	Inpatient services	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. \$100 penalty for failure to <a href="#">preauthorize</a> .
If you are pregnant	Office visits	Applicable office visit <a href="#">copay</a> /visit; 20% <a href="#">coinsurance</a> /procedures during office visit; <a href="#">deductible</a> does not apply to office visit	35% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <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	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Coverage is limited to 40 days/year; <a href="#">preauthorization</a> required; \$100 benefit reduction if failure to <a href="#">preauthorize</a> .
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a> ; 50% <a href="#">coinsurance</a> /Speech Pathologist (non-Hospital)	35% <a href="#">coinsurance</a> ; 50% <a href="#">coinsurance</a> /Speech Pathologist (non-Hospital)	Coverage for Speech Pathologist limited to 50 days/year for loss of function due to illness or injury.
	<a href="#">Habilitation services</a>	Not covered	Not covered	Coverage is excluded.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required; \$100 benefit reduction if failure to <a href="#">preauthorize</a> .
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required; \$100 benefit reduction if failure to <a href="#">preauthorize</a> .
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	None.
	Children's glasses	All charges in excess of two-calendar year limit	All charges in excess of two-calendar year period	Coverage limited to following two calendar year limits: \$240 (single), \$260 (bifocal), \$290 (trifocal) for frames and lenses.
	Children's dental check-up	No charge; dental <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a> ; dental <a href="#">deductible</a> does not apply	Coverage limited to 2 visits/12 month period.

\* For more information about limitations and exceptions, see the [plan](#) or policy document.

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Cosmetic surgery, except to repair damage from an accident, that is incidental to or follows surgery that results from trauma or infection, to enable you to eat, or as required by law
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 (specific criteria must be met)
- Chiropractic care (15 visits/year maximum)
- Dental care (Adult), \$1,500 / year
- Routine eye care (Adult), up to two-calendar year limit, including exam

**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 the Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](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](#). For more information about your rights, this notice, or assistance, contact: the Plan at 1-800-527-1647, 1-800-826-9781 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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 1-844-350-6774.

*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](#) \$500
- [Specialist copayments](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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*)

<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>	\$500
<a href="#">Copayments</a>	\$180
<a href="#">Coinsurance</a>	\$2,380
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,120</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayments](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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*)

<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>	\$120
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$780
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,320</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayments](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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*)

<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>	\$500
<a href="#">Copayments</a>	\$260
<a href="#">Coinsurance</a>	\$360
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,120</b>

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