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, visit www.umr.com or call 1-844-212-6811. 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.umr.com or call 1-844-212-6811 to request a copy. For more details on covered services, you can also call Kairos at 888-331-0222.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network $1,650 individual / $3,300 family. Out-of-Network $2,500 individual / $5,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, flu shots, pneumonia and shingles immunizations 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 http://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?	In-Network $4,500 individual / $9,000 family. Out-of-Network Not applicable	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 does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call (844) 212-6811 for a list of network providers.	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.
Is a Health Savings Account (HSA) available under this plan option?	Yes.	An HSA is an account that may be set up by you or your employer to help you plan for current and future health care costs. You may make contributions to the HSA up to a maximum amount set by the IRS.

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
		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	$20 copay/visit	50% coinsurance	Copay applies per visit regardless of what services are rendered. Includes telemedicine other than Teladoc. There is no charge, and the deductible does not apply if you receive consultation services through Teladoc.
	Specialist visit	$30 copay/visit	50% coinsurance	
	Preventive care/ screening/ immunization	No charge; deductible waived	50% coinsurance	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 for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required for certain imaging services. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.maxorplus.com	Generic drugs	$15 copay (30-day supply)/ $30 copay (90-day supply)	Not Covered	Major medical deductible applies. Covers up to a 30-day supply (retail prescription or specialty drugs); 90-day supply (retail prescription or mail order). Plan requires pharmacies to dispense generic drugs when available. Specialty drugs must be obtained directly from the specialty pharmacy. Preauthorization required for injectable medications.
	Preferred drugs	20% coinsurance ($25 min/$80 max) (30-day supply)/ 20% coinsurance ($50 min/$175 max) (90-day supply)	Not Covered	
	Non-preferred drugs	40% coinsurance ($40 min/$110 max) (30-day supply)/ 40% coinsurance ($80 min/$225 max) (90-day supply)	Not Covered	

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)	
	Specialty drugs	20% copay ($100 min/$150 max)	Not Covered	This plan will allow maintenance medications to be filled at any retail pharmacy and through mail order in 90-day quantities only. Persons benefit from paying 2 copays for a 90-day supply. Maintenance medications are subject to the retail or mail order supply limit and copays. Specialty drugs must be obtained directly from the specialty pharmacy. Preauthorization required for injectable medications.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization required for certain surgeries, including infusion therapy. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. See your plan document for a detailed listing.
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance (emergency services)/ 50% coinsurance (non - emergency services)	In-Network deductible applies to Out-of-Network benefits.
	Emergency medical transportation	20% coinsurance/ trip (ground)/ $200 copay/trip + 20% coinsurance (air)	20% coinsurance/ trip (ground)/ $200 copay/trip + 20% coinsurance (air)	In-Network deductible applies to Out-of-Network benefits.

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)	
	Urgent care	$40 copay/visit	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/admission + 20% coinsurance	$300 copay/ admission 50% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Preauthorization is required for partial hospitalization. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Inpatient services	$200 copay/admission + 20% coinsurance (facility charge)/20% coinsurance (professional fees)	$300 copay/ admission 50% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Preauthorization required for inpatient Hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. Cost sharing does not apply to preventive services from a In-Network provider. Depending on the type of services, a copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/ delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/ delivery facility services	$200 copay/admission + 20% coinsurance	$300 copay/ admission 50% 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	Home health care	20% coinsurance	50% coinsurance	60 Maximum visits per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Rehabilitation services	20% coinsurance	50% coinsurance	20 Maximum visits per plan year.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	$200 copay/ admission + 20% coinsurance	50% coinsurance	60 Maximum visits per plan year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Hospice services	20% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network	Out-of-network	
		(You will pay the least)	(You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Covered under stand alone vision plan.
	Children's glasses	Not Covered	Not Covered	Covered under stand alone vision plan.
	Children's dental check-up	Not Covered	Not Covered	Covered under stand alone dental plan.

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.)

- **Cosmetic surgery**
- **Dental care (covered under stand alone dental plan)**
- **Glasses (covered under stand alone vision plan)**
- **Infertility treatment (except diagnosis)**
- **Long-term care**
- **Private-duty nursing**
- **Routine eye care (covered under stand alone vision plan)**
- **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.)

- **Acupuncture**
- **Chiropractic care**
- **Hearing aids**
- **Non-emergency care when traveling outside the U.S.**

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-212-6811.

Traditional Chinese: (中文): 如果需要中文的幫助, 請撥打這個號碼 1-844-212-6811.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-212-6811.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-844-212-6811.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-212-6811.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-844-212-6811.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-844-212-6811.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-844-212-6811.

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** **$1,650**
- **Primary Care Physician copayment** **20%**
- **Hospital (facility) copayment** **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1650
Copayments	$200
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,610

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

- **The plan's overall deductible** **$1,650**
- **Specialist copayment** **$30**
- **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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,650
Copayments	$200
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,470

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

- **The plan's overall deductible** **$1,650**
- **Specialist copayment** **$30**
- **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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,650
Copayments	$100
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,850

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