



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 <u>deductible</u>?	\$2,800 person / \$5,600 family In-network \$5,600 person / \$11,200 family Out-of-network \$2,800 In-network / \$5,600 Out-of-network Maximum amount that any one person will satisfy towards the annual family deductible	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$2,800 person / \$5,600 family In-network \$11,200 person / \$22,400 family Out-of-network \$2,800 In-network / \$11,200 Out-of-network Maximum amount that any one person will satisfy towards the annual family out-of-pocket	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 <u>out-of-pocket limit</u>?	Penalties, <u>premiums</u> , <u>balance billing</u> charges, 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 <u>network provider</u>?	Yes. See www.umar.com or call 1-800-826-9781 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 plan's <u>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.

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> .
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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	No charge after <u>deductible</u> .	20% Coinsurance	None
	<u>Specialist</u> visit	No charge after <u>deductible</u> .	20% Coinsurance	None
	<u>Preventive care/screening/immunization</u>	No charge; Deductible Waived	20% Coinsurance	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.
	<u>Teledoc</u>	20% after <u>deductible</u>	20% after Deductible	None
	<u>Telehealth</u>	20% after <u>deductible</u>	20% after Deductible	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 test	<u>Diagnostic test</u> (x-ray, blood work)	No charge after <u>deductible</u> .	20% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge after <u>deductible</u> .	20% Coinsurance	None
If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at CostcoHealthSolutions.com .	Generic drugs (Tier 1)	0% Coinsurance after Deductible	0% Coinsurance after Deductible	Extended Day Supply: 31- 90 day supply available at Costco Retail and Mail Order pharmacies only Specialty: Manufacturer copay assistance programs do not count towards the DED and OOP maximum Specialty drugs are limited to a 30 day supply. Out of Network: Member reimbursed at contract rate – applicable copay
	Preferred brand drugs (Tier 2)	0% Coinsurance after Deductible	0% Coinsurance after Deductible	
	Non-preferred brand drugs (Tier 3)	0% Coinsurance after Deductible	0% Coinsurance after Deductible	
	<u>Specialty drugs</u> (Tier 4)	0% Coinsurance after Deductible	0% Coinsurance after Deductible	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	No charge after <u>deductible</u> .	20% 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)	
surgery	Physician/surgeon fees	No charge after <u>deductible</u> .	20% Coinsurance	None
If you need immediate medical attention	<u>Emergency room care</u>	No charge after <u>deductible</u> .	No charge after <u>deductible</u> .	In-network deductible applies to Out-of-network benefits
	<u>Emergency medical transportation</u>	No charge after <u>deductible</u> .	No charge after <u>deductible</u> .	In-network deductible applies to Out-of-network benefits; \$50,000 Maximum benefit per occurrence air ambulance
	<u>Urgent care</u>	No charge after <u>deductible</u> .	20% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after <u>deductible</u> .	20% Coinsurance	Preauthorization is required.
	Physician/surgeon fee	No charge after <u>deductible</u> .	20% Coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	No charge after <u>deductible</u> .	20% Coinsurance	Preauthorization is required for Partial hospitalization.
	Inpatient services	No charge after <u>deductible</u> .	20% Coinsurance	Preauthorization is required.

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 are pregnant	Office visits	No charge; Deductible Waived	20% Coinsurance	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	No charge after <u>deductible</u> .	20% Coinsurance	
	Childbirth/delivery facility services	No charge after <u>deductible</u> .	20% Coinsurance	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge after <u>deductible</u> .	20% Coinsurance	60 Maximum visits per calendar year; Preauthorization is required.
	<u>Rehabilitation services</u>	No charge after <u>deductible</u> .	20% Coinsurance	None
	<u>Habilitation services</u>	No charge after <u>deductible</u> .	20% Coinsurance	If your plan excludes Learning Disabilities, habilitation services for learning disabilities are not covered, please refer to your plan document.
	<u>Skilled nursing care</u>	No charge after <u>deductible</u> .	20% Coinsurance	60 Maximum days per calendar year; Preauthorization is required.
	<u>Durable medical equipment</u>	No charge after <u>deductible</u> .	20% Coinsurance	Preauthorization is required for DME in excess of \$500 for rentals or \$1,500 for purchases.

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)	
	<u>Hospice service</u>	No charge after <u>deductible</u> .	20% Coinsurance	None
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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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
- Chiropractic care (limited to 24 visits)
- Hearing aids (to age 18)
- Infertility treatment

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 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 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.

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	\$2,800
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$2,870

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$2,800
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$1,100
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
The total Joe would pay is	\$5,400

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,800
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$2,810

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.umr.com or call 1-800-826-9781.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.