




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 1-844-212-1134. 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 1-844-212-1134 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$2,500 person / \$5,000 family In-network \$5,000 person / \$10,000 family Out-of-network	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 ?	\$5,000 person / \$9,000 family In-network \$10,000 person / \$18,000 family Out-of-network	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 .
Will you pay less if you use a network provider ?	Yes. See www.umar.com or call 1-844-212-1134 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 .
 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 Premium Designated Providers; \$30 Copay per visit Non-premium Designated Providers; Deductible Waived	50% Coinsurance	None
	Specialist visit	\$30 Copay per visit Premium Designated Providers; \$60 Copay per visit Non-premium Designated Providers; Deductible Waived	50% Coinsurance	None
	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)	\$50 Copay per visit; Deductible Waived	50% 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)	
	Imaging (CT/PET scans, MRIs)	\$200 Copay per visit; Deductible Waived	50% Coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% 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.caremark.com .	Generic drugs (Tier 1)	\$10 copay for retail (30 day supply), \$25 copay for 90 day retail/mail order fill Deductible Does Not Apply	Not Covered	Specialty Drugs are only Available under the 30 Day Retail Program. CVS Customer Service: 1-855-297-2178 <u>PrudentRx Copay Program for Specialty Medications</u> In order to provide a comprehensive and cost-effective prescription drug program for you and your family, St. Vrain Valley School District has contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications. The PrudentRx Copay Program assists members by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% co-insurance. However, enrolled members who get a copay card for their specialty medication (if applicable), will have a \$0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program. For more information, please see the additional notes on page 7.
	Preferred brand drugs (Tier 2)	20% Coinsurance up to \$50 for retail (30 day supply), 20% Coinsurance up to \$125 for 90 day retail/mail order fill Deductible Does Not Apply	Not Covered	
	Non-preferred brand drugs (Tier 3)	25% Coinsurance up to \$75 for retail (30 day supply), 25% Coinsurance up to \$187.50 for 90 day retail/mail order fill Deductible Does Not Apply	Not Covered	
	Specialty drugs (Tier 4)	30% Coinsurance* for retail (30 day supply), not eligible for 90 day retail/mail order fill Deductible Does Not Apply *See PrudentRx Copay Program details	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.

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)	
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	
If you need immediate medical attention	Emergency room care	\$500 Copay per visit; Deductible Waived	\$500 Copay per visit; Deductible Waived	Copay may be waived if admitted
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits; Preauthorization is required for Non-emergent services. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
	Urgent care	\$75 Copay per visit; Deductible Waived	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	\$30 Copay per visit; Deductible Waived Office visits; 20% Coinsurance other outpatient services	\$30 Copay per visit; Deductible Waived Office visits; 50% Coinsurance other outpatient services	Preauthorization is required for Partial hospitalization . If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
	Inpatient services	20% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.

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	50% Coinsurance	Cost sharing does not apply for 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	20% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	50% Coinsurance	60 Maximum visits per calendar year combined with Private-duty nursing; Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
	Rehabilitation services	\$30 Copay per visit; Deductible Waived	50% Coinsurance	30 Maximum visits per calendar year OT; 30 Maximum visits per calendar year PT; 30 Maximum visits per calendar year ST; Habilitation services for Learning Disabilities are not covered.
	Habilitation services	\$30 Copay per visit; Deductible Waived	50% Coinsurance	
	Skilled nursing care	20% Coinsurance	50% Coinsurance	60 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.

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)	
	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 50% per occurrence.
	Hospice service	20% Coinsurance	50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	\$10 Copay per visit; Deductible Waived	\$10 Copay per visit; Deductible Waived	1 Maximum exam every 24 months; \$75 Maximum benefit every 24 months Out-of-network
	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	• Infertility treatment	• Routine foot care
• Bariatric surgery	• Long-term care	• Weight loss programs
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Hearing aids	• Routine eye care (Adult)
• Cosmetic surgery (if medically necessary)	• Private-duty nursing (Outpatient care)	

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 1-844-212-1134.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-212-1134.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-212-1134.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf die do Nummer uff 1-844-212-1134.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-212-1134.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-844-212-1134.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-844-212-1134.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-844-212-1134.

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](#) \$2,500
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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:

Cost Sharing	
Deductibles	\$2,500
Copayments	\$300
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$4,570

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$2,500
- [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
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In this example, Joe would pay:

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

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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:

Cost Sharing	
Deductibles*	\$1,000
Copayments	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$1,710

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 1-844-212-1134.

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

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.