



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 1-800-207-3172. 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 1-800-207-3172 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible? | \$800 person / \$1,600 family In-network \$1,200 person / \$2,400 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 / \$10,000 family In-network \$8,000 person / \$16,000 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 1-800-207-3172 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 | 20% Coinsurance | 40% Coinsurance | None |
| | Specialist visit | 20% Coinsurance | 40% Coinsurance | None |
| | Preventive care/screening/immunization | No charge; Deductible Waived | 40% Coinsurance to age 18; Not covered from age 18 | 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 | 40% Coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance | 40% Coinsurance | None |

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|--|---|--|---|--|
| | | In-network (You will pay the least) | Out-of-network (You will pay the most) | |
| If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.umar.com . | Tier 1 (generic and some brand-name) | \$15 Copay per prescription (retail); \$30 Copay per prescription (mail order) | If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount. | Out-of-pocket limit applies Covers up to a 31-day supply (retail); 32-90 day supply (mail order); Covers up to a 30-day supply (specialty) You must pay the difference in cost between a Generic drug and Brand-name drug when a medical professional has not specified a Brand-name drug or has not indicated that the Brand-name drug is necessary, this difference is not applied to preferred brand-name products in the high priced generic strategy, until the Out-of-pocket is met |
| | Tier 2 (preferred brand-name and some generic) | \$35 Copay per prescription (retail); \$70 Copay per prescription (mail order) | | |
| | Tier 3 (nonpreferred brand-name and nonpreferred generic) | \$35 Copay per prescription (retail); \$70 Copay per prescription (mail order) | | |
| | Tier 4 (specialty drugs) | 20% Copay up to a Maximum of \$200 per prescription | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance | 40% Coinsurance | None |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | None |
| If you need immediate medical attention | Emergency room care | 20% Coinsurance | 20% Coinsurance | In-network deductible applies to Out-of-network benefits |
| | Emergency medical transportation | 20% Coinsurance | 20% Coinsurance | In-network deductible applies to Out-of-network benefits |
| | Urgent care | 20% Coinsurance | 20% Coinsurance | In-network deductible applies to Out-of-network benefits |

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|--|---|--|---|---|
| | | In-network (You will pay the least) | Out-of-network (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | |
| If you have mental health, behavioral health, or substance abuse needs | Outpatient services | 20% Coinsurance | 40% Coinsurance | Preauthorization is required for Partial hospitalization. |
| | Inpatient services | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. |
| If you are pregnant | Office visits | No charge; Deductible Waived | 40% 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 | 40% Coinsurance | |
| | Childbirth/delivery facility services | 20% Coinsurance | 40% 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 | 40% Coinsurance | 120 Maximum visits per calendar year In-network; 60 Maximum visits per calendar year Out-of-network; Preauthorization is required. |
| | Rehabilitation services | 20% Coinsurance | 40% Coinsurance | None |
| | Habilitation services | 20% Coinsurance | 40% Coinsurance | Learning Disability is only covered for OT/PT/ST. |
| | Skilled nursing care | 20% Coinsurance | 40% Coinsurance | 120 Maximum days per confinement; Preauthorization is required. |
| | Durable medical equipment | 20% Coinsurance | 40% Coinsurance | Preauthorization is required for DME in excess of \$500 for rentals or \$1,500 for purchases. |
| | Hospice service | 20% Coinsurance | 40% Coinsurance inpatient; Not covered outpatient | None |
| If your child needs dental or eye care | Children's eye exam | No charge; Deductible Waived | 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](#).)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- 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.)

- Acupuncture (In-network only)
- Bariatric surgery (In-network only)
- Chiropractic care
- Hearing aids (to age 19)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.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](#). For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. 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 1-800-207-3172.

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](#) \$800
- [Specialist](#) [coinsurance](#) 20%
- 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

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$800 |
| Copayments | \$70 |
| Coinsurance | \$2,400 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$3,270 |

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

- The [plan's](#) overall [deductible](#) \$800
- [Specialist](#) [coinsurance](#) 20%
- 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 * | \$800 |
| Copayments | \$500 |
| Coinsurance | \$700 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,020 |

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

- The [plan's](#) overall [deductible](#) \$800
- [Specialist](#) [coinsurance](#) 20%
- 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

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles * | \$800 |
| Copayments | \$10 |
| Coinsurance | \$500 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,310 |

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 1-800-207-3172.

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