



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 1-800-332-1168. 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 1-800-332-1168 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|--|---|
| <p>What is the overall deductible?</p> | <p>\$2,800 person / \$5,600 family In-network \$2,800 person / \$5,600 family Out-of-network</p> | <p>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.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes. Preventive care services are covered before you meet your deductible.</p> | <p>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/</p> |
| <p>Are there other deductibles for specific services?</p> | <p>No.</p> | <p>You don't have to meet deductibles for specific services.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>\$5,000 person / \$10,000 family In-network \$10,000 person / \$20,000 family Out-of-network</p> | <p>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.</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p>Copayments for certain services, penalties, premiums, balance billing charges, and health care this plan doesn't cover.</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |
| <p>Will you pay less if you use a network provider?</p> | <p>Yes. See www.umar.com or call 1-800-332-1168 for a list of network providers.</p> | <p>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.</p> |
| <p>Do you need a referral to see a specialist?</p> | <p>No.</p> | <p>You can see the specialist you choose without a referral.</p> |



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 | No charge; Deductible Waived | 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. |
| 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 |

| 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 drugs to treat your illness or condition. More information about prescription drug coverage is available at www.cebt.org . | Generic drugs (Tier 1) | Deductible then, \$20 copay Retail/\$40 co-pay mail order | | None |
| | Preferred brand drugs (Tier 2) | Deductible then, \$40 copay Retail/\$80 co-pay mail order | | |
| | Non-preferred brand drugs (Tier 3) | Deductible then, \$60 copay Retail/\$120 co-pay mail order | | |
| | Specialty drugs (Tier 4) | Based on generic, preferred brand or non-preferred brand drug | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | |
| 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 | 40% 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) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. |
| | Physician/surgeon fee | 20% Coinsurance | 40% Coinsurance | |
| If you have mental health, behavioral health, or substance abuse needs | Outpatient services | 20% Coinsurance | 40% Coinsurance | None |
| | Inpatient services | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. |
| If you are pregnant | Office visits | No charge; Deductible Waived | No charge; Deductible Waived | 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 | 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 | 100 Maximum visits per calendar year; Preauthorization is required. |
| | Rehabilitation services | 20% Coinsurance | 40% Coinsurance | 20 Maximum visits per sickness or injury; Preauthorization is required. If your plan excludes Learning Disabilities, habilitation services for learning disabilities are not covered, please refer to your plan document. |
| | Habilitation services | 20% Coinsurance | 40% Coinsurance | 20 Maximum visits per sickness or injury; Preauthorization is required. If your plan excludes Learning Disabilities, habilitation services for learning disabilities are not covered, please refer to your plan document. |
| | Skilled nursing care | 20% Coinsurance | 40% Coinsurance | 45 Maximum days per calendar year; Preauthorization is required. |
| | Durable medical equipment | 20% Coinsurance | 40% Coinsurance | Repairs are only covered if the equipment is purchased; Preauthorization is required. |
| | Hospice service | 20% Coinsurance | 40% Coinsurance | None |
| If your child needs dental or eye care | Children's eye exam | No charge; Deductible Waived | No charge; Deductible Waived | 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](#).)

- Bariatric surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- 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 (when performed by a qualified practitioner or certified acupuncturist / acupressurist, for the relief of pain)
- Chiropractic care
- Cosmetic surgery (when medically necessary)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Outpatient care)
- 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 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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-332-1168.

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 | 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 | \$2,800 |
| Copayments | \$40 |
| Coinsurance | \$1,700 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,600 |

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 | 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 * | \$2,800 |
| Copayments | \$1,200 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$4,060 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$2,800 |
| ■ 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 * | \$1,900 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,900 |

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 1-800-332-1168.

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