



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](http://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](http://www.umar.com) or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <a href="#">deductible</a> ?	\$1,000 person / \$2,000 family Tier 1 \$2,000 person / \$4,000 family Tier 2 \$2,500 person / \$5,000 family Tier 3	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$4,000 person / \$8,000 family Tier 1 \$4,500 person / \$9,000 family Tier 2 \$7,500 person / \$15,000 family Tier 3	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Penalties, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.umar.com">www.umar.com</a> or call 1-800-826-9781 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (a <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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
		Tier 1	Tier 2	Tier 3	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 Copay per visit; Deductible Waived	20% Coinsurance	40% Coinsurance	None
	<a href="#">Specialist</a> visit	\$60 Copay per visit	20% Coinsurance	40% Coinsurance	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; Deductible Waived	20% Coinsurance; Deductible Waived	Not covered	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	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge; Deductible Waived PCP office setting	20% Coinsurance	40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	\$200 Copay per test	20% Coinsurance	40% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	
<b>If you need drugs to treat your illness or condition.</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> .	Generic drugs (Tier 1)	\$20 Copay per prescription (retail); \$40 Copay per prescription (mail order)			Out-of-pocket limit applies  Covers up to a 30-day supply (retail & specialty); 31-90 day supply (mail order)  Once the annual Out-of-pocket is met, you pay nothing for covered prescription medication
	Preferred brand drugs (Tier 2)	\$40 Copay per prescription (retail); \$80 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.	
	Non-preferred brand drugs (Tier 3)	\$60 Copay per prescription (retail); \$120 Copay per prescription (mail order)			
	<a href="#">Specialty drugs</a> (Tier 4)	20% Copay up to a Maximum of \$250 per prescription			
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 Copay per visit	30% Coinsurance		50% Coinsurance
	Physician/surgeon fees	\$150 Copay per visit	30% Coinsurance	50% Coinsurance	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$500 Copay per visit True ER; Not covered Non-true ER	\$500 Copay per visit True ER; Not covered Non-true ER	\$500 Copay per visit True ER; Not covered Non-true ER	Tier 1 deductible applies to Tier 2 & Tier 3 benefits; Copay may be waived if admitted True ER
	<a href="#">Emergency medical transportation</a>	\$100 Copay per trip	\$100 Copay per trip	\$100 Copay per trip	Tier 1 deductible applies to Tier 2 & Tier 3 benefits
	<a href="#">Urgent care</a>	\$75 Copay per visit; Deductible Waived	\$75 Copay per visit; Deductible Waived	\$75 Copay per visit	Tier 1 deductible applies to Tier 3 benefits

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 per day up to a Maximum of \$1,250 Copay per admission	30% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service.
	Physician/surgeon fee	No charge	30% Coinsurance	50% Coinsurance	None
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Outpatient services	\$15 Copay per visit; Deductible Waived PCP office visits; 20% Coinsurance other outpatient services	20% Coinsurance office visits; 30% Coinsurance other outpatient services	40% Coinsurance office visits; 50% Coinsurance other outpatient services	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service for Partial hospitalization.
	Inpatient services	\$250 per day up to a Maximum of \$1,250 Copay per admission	30% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service.
<b>If you are pregnant</b>	Office visits	No charge	20% Coinsurance	40% 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	30% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	\$250 per day up to a Maximum of \$1,250 Copay per admission	30% Coinsurance	50% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	20% Coinsurance	40% Coinsurance	60 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service.
	<a href="#">Rehabilitation services</a>	\$25 Copay per visit	20% Coinsurance	40% Coinsurance	20 Maximum visits per calendar year ST
	<a href="#">Habilitation services</a>	Not covered	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	No charge	20% Coinsurance	40% Coinsurance	100 Maximum days per lifetime; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service.
	<a href="#">Durable medical equipment</a>	20% Coinsurance	30% 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 per occurrence.
	<a href="#">Hospice service</a>	No charge	20% Coinsurance	40% Coinsurance	None
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	No charge; Deductible Waived	20% Coinsurance; Deductible Waived	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)
- Hearing aids
- Infertility treatment
- 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

**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](http://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](http://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](http://www.HealthCare.gov) and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

#### Does this [plan](#) Provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

#### 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 1-800-826-9781.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

**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](#) \$1,000
- [Specialist copayment](#) \$60
- Hospital (facility) [copayment](#) \$250
- Other [coinsurance](#) 0%

**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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,300</b>

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$60
- Hospital (facility) [copayment](#) \$250
- 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$600
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$6,000
<b>The total Joe would pay is</b>	<b>\$6,800</b>

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$60
- Hospital (facility) [copayment](#) \$250
- 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$1,000
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,700</b>

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](http://www.umar.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.