



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:   |
|---|--|---|
| <p>What is the overall <a href="#">deductible</a>?</p>                                | <p><b>\$3,500</b> person / <b>\$7,000</b> family In-network<br/> <b>\$3,500</b> person / <b>\$7,000</b> family Out-of-network</p>  | <p>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>.</p>  |
| <p>Are there services covered before you meet your <a href="#">deductible</a>?</p>    | <p>Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a>.</p>  | <p>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></p>   |
| <p>Are there other <a href="#">deductibles</a> for specific services?</p>             | <p>No.</p>   | <p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>  |
| <p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p> | <p><b>\$6,000</b> person / <b>\$12,000</b> family In-network<br/> <b>\$12,000</b> person / <b>\$24,000</b> family Out-of-network</p>   | <p>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.</p>   |
| <p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>               | <p><a href="#">Copayments</a> for certain services, penalties, <a href="#">premiums</a>, <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p> | <p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>   |
| <p>Will you pay less if you use a <a href="#">network provider</a>?</p>               | <p>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>.</p>   | <p>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.</p> |
| <p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>    | <p>No.</p>   | <p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</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<br>(You will pay the least) | Out-of-network<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | 20% Coinsurance                        | 40% Coinsurance                           | None  |
|  | <a href="#">Specialist</a> visit                       | 20% Coinsurance                        | 40% Coinsurance                           | None  |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge;<br>Deductible Waived        | No charge;<br>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   | <a href="#">Diagnostic test</a> (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<br>(You will pay the least)                        | Out-of-network<br>(You will pay the most) |  |
| <b>If you need drugs to treat your illness or condition.</b><br><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.cebt.org">www.cebt.org</a> | Generic drugs (Tier 1)                           | Deductible then, \$20 copay<br>Retail/\$40 co-pay mail order  |   | None   |
|  | Preferred brand drugs (Tier 2)                   | Deductible then, \$40 copay<br>Retail/\$80 co-pay mail order  |   |  |
|  | Non-preferred brand drugs (Tier 3)               | Deductible then, \$60 copay<br>Retail/\$120 co-pay mail order |   |  |
|  | <a href="#">Specialty drugs</a> (Tier 4)         | Based on generic, preferred brand or non-preferred brand drug |   |  |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)   | 20% Coinsurance   | 40% Coinsurance                           | Preauthorization is required.                            |
|  | Physician/surgeon fees                           | 20% Coinsurance   | 40% Coinsurance                           | None   |
| <b>If you need immediate medical attention</b>   | <a href="#">Emergency room care</a>              | 20% Coinsurance   | 20% Coinsurance                           | In-network deductible applies to Out-of-network benefits |
|  | <a href="#">Emergency medical transportation</a> | 20% Coinsurance   | 20% Coinsurance                           | In-network deductible applies to Out-of-network benefits |
|  | <a href="#">Urgent care</a>                      | 20% Coinsurance   | 40% Coinsurance                           | None   |

| Common Medical Event   | Services You May Need                     | What You Will Pay                      |   | Limitations, Exceptions, & Other Important Information   |
|--|---|--|---|--|
|  |   | In-network<br>(You will pay the least) | Out-of-network<br>(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                           | None   |
| 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;<br>Deductible Waived        | No charge;<br>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<br>(You will pay the least) | Out-of-network<br>(You will pay the most) |   |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | 20% Coinsurance                        | 40% Coinsurance                           | 100 Maximum visits per calendar year; Preauthorization is required.                   |
|   | <a href="#">Rehabilitation services</a>   | 20% Coinsurance                        | 40% Coinsurance                           | 20 Maximum visits per sickness or injury; Preauthorization is required.               |
|   | <a href="#">Habilitation services</a>     | Not covered                            | Not covered                               | None  |
|   | <a href="#">Skilled nursing care</a>      | 20% Coinsurance                        | 40% Coinsurance                           | 45 Maximum days per calendar year; Preauthorization is required.                      |
|   | <a href="#">Durable medical equipment</a> | 20% Coinsurance                        | 40% Coinsurance                           | Repairs are only covered if the equipment is purchased; Preauthorization is required. |
|   | <a href="#">Hospice service</a>           | 20% Coinsurance                        | 40% Coinsurance                           | None  |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No charge;<br>Deductible Waived        | No charge;<br>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 (to age 18)
- 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](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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,500 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

#### 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> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$3,500        |
| Copayments                        | \$40           |
| Coinsurance                       | \$1,600        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,200</b> |

### Managing Joe's type 2 Diabetes

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,500 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles*                      | \$3,500        |
| Copayments                        | \$1,000        |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$4,560</b> |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,500 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles*                      | \$1,900        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,900</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.