



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 1-844-586-7311. 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 1-844-586-7311 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible ? | \$2,000 person / \$4,000 family In-network \$2,000 person / \$4,000 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 , the overall family deductible must be met before the plan begins to pay. |
| 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 ? | \$4,000 person / \$6,000 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 , the overall family out-of-pocket limit must be 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 1-844-586-7311 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 | 30% Coinsurance | None |
| | Specialist visit | No charge | 30% Coinsurance | None |
| | Preventive care/screening/immunization | No charge; 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 | Diagnostic test (x-ray, blood work) | No charge | 30% Coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | No charge | 30% Coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service. |

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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.express-scripts.com . | Generic drugs (Tier 1) | \$10.00 Copay (post-Ded) \$25 Copay (post-Ded) Mail Order | \$10.00 Copay (post-Ded) | Covers up to 90 day supply (retail prescription) Covers up to 90 day supply (mail-order prescription). Your plan uses utilization management programs that require you try one or more drugs before another drug will be covered. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered. Plan sponsors may limit the quantity of a drug covered by the plan. Certain items identified by your plan as preventive care are covered in full and not subject to the co-pay amounts indicated. You pay the difference in cost if you request a brand-name drug instead of its generic equivalent. |
| | Preferred brand drugs (Tier 2) | 20% Coinsurance (post-Ded) (max \$200.00) 20% Coinsurance (max \$500 post-Ded) Mail Order | 20% Coinsurance (post-Ded) (max \$200.00) | |
| | Non-preferred brand drugs (Tier 3) | 20% Coinsurance (post-Ded) (max \$300.00) 20% Coinsurance (max \$750 post-Ded) Mail Order | 20% Coinsurance (post-Ded) (max \$300.00) | |
| | Specialty drugs (Tier 4) | 20% Coinsurance (post-Ded) (max \$300) | 20% Coinsurance (post-Ded) (max \$300) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 30% 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 fees | No charge | 30% Coinsurance | |
| If you need immediate | Emergency room care | No charge | No charge | 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) | |
| medical attention | Emergency medical transportation | No charge | No charge | In-network deductible applies to Out-of-network benefits; \$25,000 Maximum benefit per occurrence air ambulance |
| | Urgent care | No charge | 30% Coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 30% 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 | |
| If you have mental health, behavioral health, or substance abuse needs | Outpatient services | No charge | 30% Coinsurance | Preauthorization is required for Partial hospitalization. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service. |
| | Inpatient services | No charge | 30% Coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service. |
| If you are pregnant | Office visits | No charge; Deductible Waived | 30% Coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or |

| 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) | |
| | Childbirth/delivery professional services | No charge | 30% Coinsurance | coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery facility services | No charge | 30% Coinsurance | |
| If you need help recovering or have other special health needs | Home health care | No charge | 30% Coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service. |
| | Rehabilitation services | No charge | 30% Coinsurance | None |
| | Habilitation services | Not covered | Not covered | None |
| | Skilled nursing care | No charge | 30% Coinsurance | 60 Maximum days 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. |
| | Durable medical equipment | No charge | 30% 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. |
| | Hospice service | No charge | 30% 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 your child needs dental or eye care | Children's eye exam | Not covered | 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](#).)

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Hearing aids • Long-term care • Private-duty nursing | <ul style="list-style-type: none"> • 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.)

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care | <ul style="list-style-type: none"> • Infertility treatment | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. |
|--|---|--|

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](#).

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 | \$2,000 |
| ■ Specialist coinsurance | 0% |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 0% |

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 | \$2,000 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$2,070 |

Managing Joe's type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$2,000 |
| ■ Specialist coinsurance | 0% |
| ■ Hospital (facility) coinsurance | 0% |
| ■ 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles * | \$1,100 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$4,300 |
| The total Joe would pay is | \$5,400 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$2,000 |
| ■ Specialist coinsurance | 0% |
| ■ Hospital (facility) coinsurance | 0% |
| ■ 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles * | \$2,000 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$10 |
| The total Mia would pay is | \$2,010 |

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 1-844-586-7311.

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