



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 1-888-438-6105. 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 1-888-438-6105 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$1,350 person / \$2,700 family Tier 1 In-Network Tier 2 Out-of-Network (Not Covered)	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?	Yes.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	\$5,250 person / \$10,500 family Tier 1 In-Network Tier 2 Out-of-Network (Not Covered)	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 1-888-438-6105 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
		EPO Network (You will pay the least)	Non-EPO 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	\$35 Copay per visit	Not covered	None
	Specialist visit	\$55 Copay per visit	Not covered	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)	25% Coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$150 Copay per visit; 25% Coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$250 of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO Network (You will pay the least)	Non-EPO Network (You will pay the most)	
<p>If you need drugs to treat your illness or condition.</p> <p>More information about prescription drug coverage is available at www.medimpact.com</p> <p>\$1,800 OOP Max Individual \$3,600 OOP Max Family (Separate from Medical OOP Max)</p>	Generic drugs (Tier 1)	\$18 Retail/Mail; one Copayment for each 30-day supply	\$21.50 Retail	<p>Some drugs require Prior Authorization and others require Step Therapy or have quantity limits. Reference Based Pricing applies to some drugs. Please refer to your "Prescription Drug Program Summary of Benefits". Mail order up to 90-day supply on maintenance medicines. Specialty drugs applicable Copayment applies.</p> <p>OOP max does not include costs for excluded or non-covered medications or devices. Non covered medications do not go to the Rx Max OOP expense.</p>
	Preferred brand drugs (Tier 2)	\$62 Retail/Mail; one Copayment for each 30-day supply	\$65.50 Retail	
	Non-preferred brand drugs (Tier 3)	\$97 Retail/Mail; one Copayment for each 30-day supply	\$100.50 Retail	
	Specialty drugs	\$18 Tier 1 \$62 Tier 2 \$97 Tier 3	\$21.50 Tier 1 \$65.50 Tier 2 \$100.50 Tier 3	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	\$160 Copay per visit; 25% Coinsurance	Not covered	<p>Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$250 of the total cost of the service.</p>
	Physician/surgeon fees	25% Coinsurance	Not covered	
<p>If you need immediate medical attention</p>	Emergency room care	\$350 Copay per visit; 25% Coinsurance	\$350 Copay per visit; 25% Coinsurance	Copay may be waived if admitted
	Emergency medical transportation	\$100 Copay per trip; Deductible Waived	\$100 Copay per trip; Deductible Waived	Copay may be waived if admitted

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO Network (You will pay the least)	Non-EPO Network (You will pay the most)	
	Urgent care	\$55 Copay per visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 Copay per admission; 25% Coinsurance	Not covered	Maximum combined Inpatient Copay per calendar year is \$1,200 per person, no more than one Copay per 30 calendar days; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$250 of the total cost of the service.
	Physician/surgeon fee	25% Coinsurance	Not covered	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$35 Copay per visit. Day Treatment: \$150 Copay for first day only; 25% Coinsurance. All other Outpatient Services: \$160 Copay per visit; 25% Coinsurance.	Not covered	Preauthorization is required for Partial hospitalization. If you don't get preauthorization, benefits could be reduced by \$250 of the total cost of the service.
	Inpatient services	\$300 Copay per admission; 25% Coinsurance	Not covered	Maximum combined Inpatient Copay per calendar year is \$1,200 per person, no more than one Copay per 30 calendar days; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$250 of the total cost of the service.
If you are pregnant	Office visits	25% Coinsurance	Not covered	Maximum combined Inpatient Copay per calendar year is \$1,200 per person, no more than one Copay per 30 calendar days; 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	25% Coinsurance	Not covered	
	Childbirth/delivery facility services	\$300 Copay per admission; 25% Coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO Network (You will pay the least)	Non-EPO Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	25% Coinsurance	Not covered	40 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$250 of the total cost of the service.
	Rehabilitation services	\$55 Copay for evaluation; 25% Coinsurance	Not covered	Limited to 30 visits per calendar year, combined with Physical Therapy, Occupational Therapy, Speech Therapy and Chiropractic care; Habilitation services for Learning Disabilities are not covered.
	Habilitation services	25% Coinsurance	Not covered	
	Skilled nursing care	\$300 Copay per admission; 25% Coinsurance	Not covered	Maximum combined Inpatient Copay per calendar year is \$1,200 per person, no more than one Copay per 30 calendar days; Copay waived if transferred from an Acute Care Facility; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$250 of the total cost of the service.
	Durable medical equipment	25% Coinsurance	Not covered	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 \$250 per occurrence.
	Hospice service	25% Coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$35 Copay per visit	Not covered	1 Maximum exam per calendar year
	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](#).)

- Acupuncture
- 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.)

- Bariatric surgery (EPO only)
- Chiropractic care (EPO only)
- Hearing aids (EPO only)
- Infertility treatment (EPO only)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (EPO only)

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$1,350	■ The plan's overall deductible	\$1,350	■ The plan's overall deductible	\$1,350
■ Specialist copayment	\$55	■ Specialist copayment	\$55	■ Specialist copayment	\$55
■ Hospital (facility) copayment	\$300	■ Hospital (facility) copayment	\$300	■ Hospital (facility) copayment	\$300
■ Other coinsurance	25%	■ Other coinsurance	25%	■ Other coinsurance	25%
<p>This EXAMPLE event includes services like: Specialist office visits (<i>pre-natal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$1,350	Deductibles *	\$200	Deductibles *	\$1,350
Copayments	\$300	Copayments	\$300	Copayments	\$400
Coinsurance	\$1,900	Coinsurance	\$0	Coinsurance	\$300
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$70	Limits or exclusions	\$4,300	Limits or exclusions	\$10
The total Peg would pay is	\$3,620	The total Joe would pay is	\$4,800	The total Mia would pay is	\$2,060

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 1-888-438-6105.

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