



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>\$1,350 person / \$2,700 person +1 / \$2,700 family Tier 1                      \$2,500 person / \$5,000 person +1 / \$5,000 family Tier 2                      \$5,000 person / \$10,000 person +1 / \$10,000 family Tier 3</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>, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.</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 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>\$5,000 person / \$10,000 person +1 / \$10,000 family Tier 1                      \$5,200 person / \$10,400 person +1 / \$10,400 family Tier 2                      \$6,650 person / \$13,300 person +1 / \$13,300 family Tier 3                      \$6,650 Tier 1 / \$6,650 Tier 2 / \$6,650 Tier 3 Maximum amount that any one person will satisfy towards the annual family out-of-pocket</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>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
		Tier 1	Tier 2	Tier 3	Tier 4	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	None
	<a href="#">Specialist</a> visit	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; Deductible Waived	No charge; Deductible Waived	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	<a href="#">Diagnostic test</a> (x-ray, blood work)	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	Not covered if not medically necessary.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
<p><b>If you need drugs to treat your illness or condition.</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.umar.com">www.umar.com</a>.</p>	Generic drugs (Tier 1)	35% Coinsurance with a Minimum of \$10 up to a Maximum of \$100 per prescription (retail); 35% Coinsurance with a Minimum of \$20 up to a Maximum of \$200 per prescription (mail order)			Not covered	<p>Deductible and Out-of-pocket limit applies</p> <p>Covers up to a 30-day supply (retail &amp; specialty); 31-90 day supply (mail order)</p> <p>Diabetic drugs 30-day supply retail: No charge (generic); 20% Coinsurance with a Minimum of \$30 up to a Maximum of \$100 per prescription (preferred); 50% Coinsurance with a Minimum of \$50 up to a Maximum of \$120 per prescription (non-preferred); 90-day supply mail order: No charge (generic); 20% Coinsurance with a Minimum of \$60 up to a Maximum of \$200 per prescription (preferred); 50% Coinsurance with a Minimum of \$100 up to a Maximum of \$230 per prescription</p> <p>Diabetic supplies 30-day supply retail: No charge (generic &amp; preferred); 20% Coinsurance with a Minimum of \$30 up to a Maximum of \$100 per prescription (non-preferred); 90-day supply mail order: No charge (generic &amp; preferred); 20% Coinsurance with a Minimum of \$60 up to a Maximum of \$200 per prescription (non-preferred)</p> <p>You must pay the difference in cost between a Generic drug and Brand-name drug when a medical professional has not specified a Brand-name drug or has not indicated that the Brand-name drug is necessary, until the out-of-pocket is met</p>
	Preferred brand drugs (Tier 2)	35% Coinsurance with a Minimum of \$40 up to a Maximum of \$120 per prescription (retail); 35% Coinsurance with a Minimum of \$70 up to a Maximum of \$230 per prescription (mail order)				
	Non-preferred brand drugs (Tier 3)	50% Coinsurance with a Minimum of \$60 up to a Maximum of \$150 per prescription (retail); 50% Coinsurance with a Minimum of \$120 up to a Maximum of \$250 per prescription (mail order)				
	<a href="#">Specialty drugs</a> (Tier 4)	35% Coinsurance with a Minimum of \$90 up to a Maximum of \$170 per prescription				

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	None
	Physician/surgeon fees	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	15% Coinsurance True ER; 25% Coinsurance Non-true ER	20% Coinsurance True ER; 30% Coinsurance Non-true ER	20% Coinsurance True ER; 30% Coinsurance Non-true ER	20% Coinsurance True ER; 30% Coinsurance Non-true ER	Tier 2 deductible applies to Tiers 3 & 4 benefits
	<a href="#">Emergency medical transportation</a>	15% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance	Tier 2 deductible applies to Tiers 3 & 4 benefits; \$10,000 Maximum benefit per calendar year Air ambulance
	<a href="#">Urgent care</a>	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	Preauthorization is required.
	Physician/surgeon fee	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	Preauthorization is required for Partial hospitalization.
	Inpatient services	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
<b>If you are pregnant</b>	Office visits	No charge; Deductible Waived	No charge; Deductible Waived	No charge; Deductible Waived	Not covered	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	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	
	Childbirth/delivery facility services	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	60 Maximum visits per calendar year; Preauthorization is required.
	<a href="#">Rehabilitation services</a>	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	60 Maximum visits per calendar year
	<a href="#">Habilitation services</a>	Not covered	Not covered	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	60 Maximum days per calendar year; Preauthorization is required.
	<a href="#">Durable medical equipment</a>	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	Preauthorization is required.
	<a href="#">Hospice service</a>	15% Coinsurance	20% Coinsurance	60% Coinsurance	Not covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	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 (except when medically necessary)
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- 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 (Tier 2 only)
- Chiropractic care (Tiers 1, 2 & 3 only)
- Non-emergency care when traveling outside the U.S. (Tiers 1, 2 & 3 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](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.

<b>Peg is Having a Baby</b> (9 months of in-network pre-natal care and a hospital delivery)		<b>Managing Joe's type 2 Diabetes</b> (a year of routine in-network care of a well-controlled condition)		<b>Mia's Simple Fracture</b> (in-network emergency room visit and follow up care)																																											
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<b>This EXAMPLE event includes services like:</b> Specialist office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests ( <i>ultrasounds and blood work</i> ) Specialist visit ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> 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> )		<b>This EXAMPLE event includes services like:</b> 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> )																																											
<b>Total Example Cost</b>	<b>\$12,800</b>	<b>Total Example Cost</b>	<b>\$7,400</b>	<b>Total Example Cost</b>	<b>\$1,900</b>																																										
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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: You don't have to meet other [deductibles](#) for specific services. See "Are there other deductibles for specific services?" row above.