



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 1-800-826-9781. 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 or call 1-800-826-9781 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible? | \$3,300 person / \$6,300 family In-network \$6,000 person / \$12,000 family Out-of-network \$3,300 In-network / \$6,000 Out-of-network Maximum amount that any one person will satisfy toward the annual family deductible | 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? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | \$5,000 person / \$10,000 family In-network \$10,000 person / \$20,000 family Out-of-network \$5,000 In-network / \$10,000 Out-of-network Maximum amount that any one person will satisfy toward the annual family out-of-pocket | 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 1-800-826-9781 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 | \$20 Copay per visit | 40% Coinsurance | None |
| | Specialist visit | \$60 Copay per visit | 40% Coinsurance | None |
| | Preventive care/screening/immunization | No charge; Deductible Waived | 40% Coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | \$20 Copay per visit PCP; \$60 Copay per visit Specialist office setting; 10% Coinsurance outpatient setting | 40% Coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | \$20 Copay per visit PCP; \$60 Copay per visit Specialist office setting; 10% Coinsurance outpatient setting | 40% 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 you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.umar.com . | Tier 1 (generic and some brand-name) | \$12 Copay per prescription (retail); \$24 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. | Deductible and Out-of-pocket limit applies Covers up to a 30-day supply (retail); 31-90 day supply (mail order); Covers up to a 30-day supply (specialty) 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, this difference is not applied to preferred brand-name products in the high priced generic strategy, until the out-of-pocket is met |
| | Tier 2 (preferred brand-name and some generic) | \$30 Copay per prescription (retail); \$60 Copay per prescription (mail order) | | |
| | Tier 3 (nonpreferred brand-name and nonpreferred generic) | \$75 Copay per prescription (retail); \$150 Copay per prescription (mail order) | | |
| | Tier 4 (specialty drugs) | \$100 Copay per prescription | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% Coinsurance | 40% Coinsurance | None |
| | Physician/surgeon fees | 10% Coinsurance | 40% Coinsurance | None |
| If you need immediate medical attention | Emergency room care | \$300 Copay per visit | \$300 Copay per visit | In-network deductible applies to Out-of-network benefits; Copay may be waived if admitted |
| | Emergency medical transportation | 10% Coinsurance | 10% Coinsurance | In-network deductible applies to Out-of-network benefits; Preauthorization is required for Non-emergency services. If you don't get preauthorization , benefits could be reduced by \$500 of the total cost of the service. |
| | Urgent care | \$125 Copay per visit | \$125 Copay per visit | In-network deductible applies to Out-of-network benefits |

| 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 have a hospital stay | Facility fee (e.g., hospital room) | 10% 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. |
| | Physician/surgeon fees | 10% Coinsurance | 40% Coinsurance | |
| If you have mental health, behavioral health, or substance abuse services | Outpatient services | \$20 Copay per office visit; 10% Coinsurance other outpatient services | 40% 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 | 10% 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. |
| If you are pregnant | Office visits | No charge; Deductible Waived | 40% Coinsurance | Cost sharing does not apply for 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 | 10% Coinsurance | 40% Coinsurance | |
| | Childbirth/delivery facility services | 10% Coinsurance | 40% Coinsurance | |

| 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 need help recovering or have other special health needs | Home health care | 10% 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. |
| | Rehabilitation services | \$20 Copay per visit | 40% Coinsurance | 60 Maximum visits per calendar year; Habilitation services for Learning Disabilities are not covered. |
| | Habilitation services | \$20 Copay per visit | 40% Coinsurance | |
| | Skilled nursing care | 10% Coinsurance | 40% Coinsurance | 45 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 | 10% Coinsurance | 40% 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 | 10% Coinsurance | 40% Coinsurance | None |
| 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• Bariatric surgery• Cosmetic surgery• Dental care (Adult) | <ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S.• Private-duty nursing (unless under Home health care) | <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">• Chiropractic care | <ul style="list-style-type: none">• Hearing aids | |

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 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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-826-9781.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-826-9781.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-826-9781.

Pennsylvania Dutch (Deitsch): Fer Hilf griegie in Deitsch, ruf die do Nummer uff 1-800-826-9781.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-826-9781.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-826-9781.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-800-826-9781.

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](#) \$3,300
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$3,300 |
| Copayments | \$50 |
| Coinsurance | \$800 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$4,150 |

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

- The [plan's](#) overall [deductible](#) \$3,300
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles* | \$3,300 |
| Copayments | \$700 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$4,020 |

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

- The [plan's](#) overall [deductible](#) \$3,300
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles* | \$2,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,800 |

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.umr.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.