



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 1-800-207-3172. 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 1-800-207-3172 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$3,300 person / \$5,000 family In-network \$3,300 person / \$6,000 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?	\$4,500 person / \$7,700 family In-network \$5,000 person / \$9,000 family Out-of-network \$4,500 In-network / \$5,000 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 .
	Copays for certain specialty prescription drugs considered non-essential health benefits under the plan. The copays for these drugs (though manufacturer copay assistance programs may support some fills at no remaining cost to you) will not apply towards satisfying your out-of-pocket maximum or any applicable deductible.	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 1-800-207-3172 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.



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% Coinsurance	30% Coinsurance	None
	Specialist visit	20% Coinsurance	30% Coinsurance	None
	Preventive care/screening/immunization	No charge; Deductible Waived	30% Coinsurance	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)	20% Coinsurance	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	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 you need drugs to treat your illness or condition. More information about prescription drug coverage is available at Express Scripts https://www.express-scripts.com	Generic drugs (Tier 1)	\$15 / prescription (retail) and \$30 / prescription (home delivery) after deductible	Not Covered (retail and home delivery)	Once the Out-of-Pocket maximum has been met, prescription drug shall be covered at 100% for the remainder of the calendar year. Covers up to a 34-day supply (retail prescription); 90-day supply (mail orders or Smart90 retail prescription). Certain prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations. Patient must pay the cost difference between the brand and generic drug in addition to your copay or coinsurance. * Copays for certain specialty prescription drugs considered non-essential health benefits under the plan bypass your out-of-pocket limit. Please see "Important Questions" regarding the plan's out-of-pocket limit. See Plan Documents for additional information on the SaveonSP Program. Out-of-Network RX reimbursed at 100% minus applicable copayment by filing RX claim form.
	Preferred brand drugs (Tier 2)	\$45 / prescription (retail) and \$90 / prescription (home delivery) after deductible	Not Covered (retail and home delivery)	
	Non-preferred brand drugs (Tier 3)	\$85 / prescription (retail) and \$170 / prescription (home delivery) after deductible	Not Covered (retail and home delivery)	
	Specialty drugs (Tier 4)	\$100 / prescription (retail) and \$200 / prescription (home delivery) after deductible	Not Covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	30% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	30% Coinsurance	None
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits; \$25,000 Maximum benefit per occurrence air Ambulance; 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	20% Coinsurance	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 you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	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	20% Coinsurance	30% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	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	20% Coinsurance	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 coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% Coinsurance	30% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	30% 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	20% Coinsurance	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	20% Coinsurance	30% Coinsurance	62 Maximum visits per calendar year; If your plan excludes Learning Disabilities, habilitation services for learning disabilities are not covered, please refer to your plan document.
	Habilitation services	20% Coinsurance	30% Coinsurance	
	Skilled nursing care	20% Coinsurance	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	20% Coinsurance	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	20% Coinsurance	30% Coinsurance	Life expectancy up to 12 months
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived to age 6	30% Coinsurance to age 6	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
- Hearing aids
- Routine eye care (Adult)
- Cosmetic surgery
- Infertility treatment
- Routine foot care
- Dental care (Adult)
- Long-term 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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Chiropractic care

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](#).

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	\$3,200
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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*)

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,300
Copayments	\$0
Coinsurance	\$1,866
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$5,236

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$3,200
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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*)

In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$1,100
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$4,500
The total Joe would pay is	\$5,600

■ The plan's overall deductible	\$3,200
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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*)

In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$2,790
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$10
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.umar.com or call 1-800-207-3172.

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