



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 ?	\$1,500 person / \$3,000 family In-network \$1,750 person / \$3,500 family Out-of-network Copayments do not apply to the <u>deductible</u> .	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 ?	\$3,000 person / \$6,000 family In-network \$3,500 person / \$7,000 family Out-of-network Rx Out-of-Pocket Maximums: \$5,200 person/ \$10,400 family	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 (a 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% Coinsurance \$10 Copay for Teladoc	30% Coinsurance	Deductible Waived In-network; To schedule a Teladoc visit you must set up your account at www.Teladoc.com or by calling 1-800-Teladoc.
	Specialist visit	20% Coinsurance; Chiropractic care; Not covered Acupuncture	30% Coinsurance	Deductible Waived In-network Chiropractic care
	Preventive care/screening/immunization	No charge	No charge	Deductible Waived
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	30% Coinsurance	Deductible Waived In-network
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	30% Coinsurance	Deductible Waived In-network if performed in a clinic setting. Deductible Applies if performed in a hospital setting.

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.medone-rx.com	Generic drugs	20% Coinsurance with \$20 maximum per fill for 30-day supply 20% Coinsurance with \$60 maximum per fill for 91-day supply	Not Covered	<u>Rx Out-of-Pocket Maximums</u> \$5,200 Rx for Individuals \$10,400 for Rx for Families <u>Mail-order Pharmacy 90-day supply:</u> Generic: 20% up to \$40 maximum per fill Non-specialty brands: 20% up to \$120 maximum per fill RxAlly is offered as part of your plan's specialty drug coverage. RxAlly Patient Care Coordinators will help you pursue drug manufacturer assistance programs and/or patient assistance programs. Coverage for certain specialty drugs may be available under the plan if manufacturer or patient assistance cannot be obtained.
	Brand drugs	20% Coinsurance with \$60 maximum per fill for 30-day supply 20% Coinsurance with \$180 maximum per fill for 91-day supply	Not Covered	
	Specialty drugs	For assistance acquiring specialty medications, please contact RxAlly at 877-794-2218	Not Covered	
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
	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, benefit reduces by 50% up to a \$500 Maximum per claim
	Physician/surgeon fee	20% Coinsurance	30% Coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% Coinsurance	30% Coinsurance	Deductible Waived In-network office visit.
	Inpatient services	20% Coinsurance	30% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefit reduces by 50% up to a \$500 Maximum per claim
If you are pregnant	Office visits	No charge Prenatal; 20% Coinsurance Postnatal	30% Coinsurance	Deductible Waived Prenatal
	Childbirth/delivery professional services	20% Coinsurance	30% Coinsurance	None
	Childbirth/delivery facility services	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 help recovering or have other special health needs	Home health care	20% Coinsurance	30% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefit reduces by 50% up to a \$500 Maximum per claim
	Rehabilitation services	20% Coinsurance	30% Coinsurance	Deductible Waived In-network office therapy
	Habilitation services	20% Coinsurance	20% Coinsurance	None
	Skilled nursing care	20% Coinsurance;	30% Coinsurance	90 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefit reduces by 50% up to a \$500 Maximum per claim
	Durable medical equipment	20% Coinsurance	30% Coinsurance	Preauthorization is required for DME in excess of \$500 for rentals or \$1,500 for purchases or benefit reduces by 50% up to a \$500 Maximum per claim.
	Hospice service	20% Coinsurance	30% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Deductible Waived; 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](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|-----------------------|-------------------------|------------------------|
| • Acupuncture | • Hearing aids | • Routine foot care |
| • Cosmetic surgery | • Infertility treatment | • Weight loss programs |
| • Dental care (adult) | • Long-term care | |

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

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|---------------------|--|----------------------------|
| • Bariatric surgery | • Non-emergency care when traveling outside the U.S. | • Routine eye care (adult) |
| • Chiropractic care | • Private-duty nursing (Outpatient only – covered for Home Health Care 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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.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](#). For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov.

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.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

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[* For more information about limitations and exceptions, see the [plan](#) document.]

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	\$1,500
■ Specialist copayment	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,160
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$2,660

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$1,500
Copayments	\$0
Coinsurance	\$620
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,120

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	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*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$1,500
Copayments	\$0
Coinsurance	\$670
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,170

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 1-800-826-9781.

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