



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 ?	\$8,550 person / \$17,100 family In-network \$17,100 person / \$34,200 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 , 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 ?	\$8,550 person / \$17,100 family In-network \$17,100 person / \$34,200 family Out-of-network	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	0% coinsurance after deductible	0% coinsurance after deductible	None
	Specialist visit	0% coinsurance after deductible Chiropractic care; Not covered Acupuncture	0% coinsurance after deductible Chiropractic care; Not covered Acupuncture	None
	Preventive care/screening/immunization	No charge, Deductible Waived	No charge, Deductible Waived	None
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance after deductible	0% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	0% coinsurance after deductible	None

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

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 Drug	0% coinsurance after deductible	Not Covered	Members may experience cost savings by utilizing 90 day refill at retail, or 90-day Mail Order with MedOne Pharmacy services. Contact MedOne at 877-896-0919 to obtain lowest cost fill options. Note: Walgreens and Walmart/Sam's Club are excluded from the network.
	Brand Drug	0% coinsurance after deductible	Not Covered	
	Specialty Drug	0% coinsurance after deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	0% coinsurance after deductible	None
	Physician/surgeon fees	0% coinsurance after deductible	0% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	0% coinsurance after deductible	0% coinsurance after deductible	In-network deductible applies to Out-of-network benefits
	Emergency medical transportation	0% coinsurance after deductible	0% coinsurance after deductible	In-network deductible applies to Out-of-network benefits
	Urgent care	0% coinsurance after deductible	0% coinsurance after deductible	None

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

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)	0% coinsurance after deductible	0% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefit reduces by 50% up to a \$500 Maximum per claim.
	Physician/surgeon fee	0% coinsurance after deductible	0% coinsurance after deductible	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	0% coinsurance after deductible	0% coinsurance after deductible	None
	Inpatient services	0% coinsurance after deductible	0% coinsurance after deductible	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	Deductible Waived Prenatal; 0% coinsurance after deductible Postnatal	Deductible Waived Prenatal; 0% coinsurance after deductible Postnatal	
	Childbirth/delivery professional services	0% coinsurance after deductible	0% coinsurance after deductible	
	Childbirth/delivery facility services	0% coinsurance after deductible	0% coinsurance after deductible	

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

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	0% coinsurance after deductible	0% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefit reduces by 50% up to a \$500 Maximum per claim.
	Rehabilitation services	0% coinsurance after deductible	0% coinsurance after deductible	None
	Habilitation services	0% coinsurance after deductible	0% coinsurance after deductible	None
	Skilled nursing care	0% coinsurance after deductible	0% coinsurance after deductible	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	0% coinsurance after deductible	0% coinsurance after deductible	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	0% coinsurance after deductible	0% coinsurance after deductible	None
If your child needs dental or eye care	Children's eye exam	Deductible Waived; 1 Maximum exam per calendar year	Deductible Waived; 1 Maximum exam per calendar year	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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

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
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- 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
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Outpatient care – Home Health care only)
- Routine eye care (adult)

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.*—————

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

[* 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](#) \$8,550
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$8,550
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$8,550

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

- The [plan's](#) overall [deductible](#) \$8,550
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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	\$9,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$8,550
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$8,550

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

- The [plan's](#) overall [deductible](#) \$8,550
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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.