



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:
<b>What is the overall <a href="#">deductible</a>?</b>	\$500 person / \$1,000 family In-network \$2,500 person / \$5,000 family Out-of-network	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> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	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 <a href="#">copayment</a> or <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>
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$6,850 person / \$13,700 family In-network \$8,000 person / \$16,000 family Out-of-network	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Penalties, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, prescription drugs, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the medical <a href="#">out-of-pocket limit</a> . Prescription drugs have a separate out of pocket limit.
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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> .	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 <a href="#">plan's 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 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 Copay per visit; Deductible Waived	\$60 Copay per visit; 25% coinsurance	None
	<a href="#">Specialist</a> visit	\$65 Copay per visit; Deductible Waived	\$130 Copay per visit; 25% coinsurance	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; Deductible Waived	\$50 Copay per exam; 25% Coinsurance Preventive care; 25% Coinsurance Preventive screenings & Immunizations	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	5% Coinsurance	25% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	5% Coinsurance	25% Coinsurance	None

<b>If you need drugs to treat your illness or condition.</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.proactrx.com">www.proactrx.com</a>	Generic drugs (Tier 1)	\$15 Copay	No Coverage	Pre-authorization may be required. If not obtained, member is responsible for 100% of the cost of the drug.
	Preferred brand drugs (Tier 2)	\$50 Copay	No Coverage	Prescription Drugs are subject to a \$2,000 individual / \$4,000 family pharmacy Out of Pocket Maximum. Combined medical and pharmacy out of pocket maximum is \$8,850 individual / \$17,700 family.
	Non-preferred brand drugs (Tier 3)	\$150 Copay	No Coverage	
	<a href="#">Specialty drugs</a> (Tier 4)	25% coinsurance; deductible does not apply.	No Coverage	Specialty medications must be obtained through Noble Health Services Specialty Pharmacy. <a href="http://www.noblehealthservices.com">www.noblehealthservices.com</a>
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	5% Coinsurance	25% Coinsurance	None
	Physician/surgeon fees	5% Coinsurance	25% Coinsurance	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$500 Copay per visit; 5% Coinsurance	\$500 Copay per visit; 5% Coinsurance	In-network deductible applies to Out-of-network benefits; Copay may be waived if admitted
	<a href="#">Emergency medical transportation</a>	5% Coinsurance	5% Coinsurance	In-network deductible applies to Out-of-network benefits
	<a href="#">Urgent care</a>	\$100 Copay per visit; 5% Coinsurance	\$100 Copay per visit; 25% Coinsurance	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	5% Coinsurance	25% Coinsurance	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% not to exceed \$1,000 of the total cost of the service.
	Physician/surgeon fees	5% Coinsurance	25% Coinsurance	

<b>If you have mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 Copay per visit; Deductible Waived office visits; 5% Coinsurance other outpatient services	\$60 Copay per visit; 25% Coinsurance other outpatient services	<a href="#">Preauthorization</a> is required for Partial <a href="#">hospitalization</a> . If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% not to exceed \$1,000 of the total cost of the service.
	Inpatient services	5% Coinsurance	25% Coinsurance	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% not to exceed \$1,000 of the total cost of the service.
<b>If you are pregnant</b>	Office visits	No charge; Deductible Waived	25% Coinsurance	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">deductible</a> , <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	5% Coinsurance	25% Coinsurance	
	Childbirth/delivery facility services	5% Coinsurance	25% Coinsurance	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	5% Coinsurance	25% Coinsurance	60 Maximum visits per calendar year; <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% not to exceed \$1,000 of the total cost of the service.
	<a href="#">Rehabilitation services</a>	\$30 Copay per visit	\$60 Copay per visit; 25% Coinsurance	None
	<a href="#">Habilitation services</a>	\$30 Copay per visit	\$60 Copay per visit; 25% Coinsurance	Habilitation services for Learning Disabilities are not covered.
	<a href="#">Skilled nursing care</a>	5% Coinsurance	25% Coinsurance	30 Maximum days per confinement;

				<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% not to exceed \$1,000 of the total cost of the service.
	<a href="#">Durable medical equipment</a>	5% Coinsurance	25% Coinsurance	<a href="#">Preauthorization</a> is required for DME in excess of \$500 for rentals or \$1,500 for purchases. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% not to exceed \$1,000 per occurrence.
	<a href="#">Hospice service</a>	5% Coinsurance	25% Coinsurance	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge; Deductible Waived	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](#) Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)**

- |                     |                         |                        |
|---------------------|-------------------------|------------------------|
| • Acupuncture       | • Dental care (Adult)   | • Private-duty nursing |
| • Bariatric surgery | • Infertility treatment | • Routine foot care    |
| • Cosmetic surgery  | • 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.)**

- |                              |  |                            |
|------------------------------|--|----------------------------|
| • Chiropractic care          | • Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult) |
| • Hearing aids (from age 18) |  |                            |

**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 18003182596.

**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](http://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](#) \$500
- [Specialist copayment](#) \$65
- Hospital (facility) [coinsurance](#) 5%
- Other [coinsurance](#) 5%

**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>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$1,070</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$65
- Hospital (facility) [coinsurance](#) 5%
- Other [coinsurance](#) 5%

**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>	
<a href="#">Deductibles</a> *	\$400
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$5,000</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$65
- Hospital (facility) [coinsurance](#) 5%
- Other [coinsurance](#) 5%

**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>	
<a href="#">Deductibles</a> *	\$500
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$1,280</b>

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