
 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 call 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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">network providers</a> \$1,300 individual / \$2,600 family	Generally, you must pay all of the costs from providers 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	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>
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$3,000 individual / \$6,000 family	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	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 provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">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 provider's 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> */visit	Not covered	None
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> */visit	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$10 <a href="#">copay</a> */visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$25 <a href="#">copay</a> */visit	Not covered	<a href="#">Preauthorization</a> required: PET/CT scans, MRA, MRS, MRI, and nuclear cardiac imaging.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.cvshealth.com">www.cvshealth.com</a>	Generic drugs	<a href="#">copay</a> */prescription: Retail: \$10 for 30 day, \$20 for 31-60 days, \$30 for 61-100 days; Mail order: \$10 for 30 day, \$20 for 31-100 day	Not covered	Covers up to a 100-day supply (retail or mail order prescription).
	Preferred brand drugs	<a href="#">copay</a> */prescription: Retail: \$25 for 30 day, \$50 for 31-60 day, \$75 for 61-100 day; Mail order: \$25 for 30 day, \$50 for 31-100 day	Not covered	
	Non-preferred brand drugs	<a href="#">copay</a> */prescription: Retail: \$25 for 30 day, \$50 for 31-60 day, \$75 for 61-100 day; Mail order: \$25 for 30 day, \$50 for 31-100 day	Not covered	Only covered if determined to be medically necessary through clinical review. Covers up to a 100-day supply (retail or mail order).
	<a href="#">Specialty drugs</a>	See above limits	Not covered	Covers up to a 100-day supply (retail or mail order prescription).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <a href="#">copay</a> */visit	Not covered	None
	Physician/surgeon fees	Office: \$20 <a href="#">copay</a> */visit. Other: no charge*	Not covered	<a href="#">Preauthorization</a> required
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$75 <a href="#">copay</a> */visit	\$75 <a href="#">copay</a> */visit	<a href="#">copay</a> waived if admitted
	<a href="#">Emergency medical transportation</a>	\$50 <a href="#">copay</a> *	\$50 <a href="#">copay</a> *	None
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a> */visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 <a href="#">copay</a> */visit	Not covered	<a href="#">Preauthorization</a> required
	Physician/surgeon fees	No charge*	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Individual therapy: \$20 <a href="#">copay</a> */visit. Group therapy: \$10 <a href="#">copay</a> */visit	Not covered	Substance abuse group therapy: \$5 <a href="#">copay</a> */visit
	Inpatient services	General hospital/private proprietary psychiatric facility/certified alcohol/substance use disorder facility: \$150 <a href="#">copay</a> *. Partial hospitalization or intensive outpatient: no charge*	Not covered	<a href="#">Preauthorization</a> required. Substance abuse partial hospitalization or intensive outpatient: \$5 <a href="#">copay</a> */visit. Transitional Residential facility: \$50 <a href="#">copay</a> *.
If you are pregnant	Office visits	No charge*	Not covered	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <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	No charge*	Not covered	
	Childbirth/delivery facility services	\$150 <a href="#">copay</a> *	Not covered	Depending on the type of services, <a href="#">Cost sharing</a> may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge*	Not covered	Limited to 100 visits/year; 3 visits/person/day.
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> */visit	Not covered	None
	<a href="#">Habilitation services</a>			
	<a href="#">Skilled nursing care</a>	\$200 <a href="#">copay</a> */visit	Not covered	<a href="#">Preauthorization</a> required. Limited to 100 days/year
	<a href="#">Durable medical equipment</a>	\$20 <a href="#">copay</a> */visit	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	No charge*	Not covered	Respite care: Limited to 5 consecutive days/admission.
If your child needs dental or eye care	Children's eye exam	\$10 <a href="#">copay</a> */visit	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

\* [deductible](#) applies

#### 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](#).)

<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care</li> <li>• Infertility Treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S. unless travel is for the sole purpose of obtaining medical services</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul>
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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"> <li>• Acupuncture (if prescribed for rehabilitation purposes)</li> <li>• Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care</li> <li>• Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>• Private Duty Nursing (inpatient only)</li> <li>• Routine Eye Care (Adult)</li> </ul>
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**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 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 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: UMR Claims Appeal Unit, PO Box 30546, Salt Lake City, UT 84130-0546, [www.umar.com](http://www.umar.com).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? 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 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1300
■ <a href="#">Specialist</a>	\$20
■ Hospital (facility)	0%
■ Other	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*)

<b>Total Example Cost</b>	<b>\$13924</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1300
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1600</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1300
■ <a href="#">Specialist</a>	\$20
■ Hospital (facility)	0%
■ Other	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*)

<b>Total Example Cost</b>	<b>\$7541</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1300
Copayments	\$1000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2320</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1300
■ <a href="#">Specialist</a>	\$20
■ Hospital (facility)	0%
■ Other	0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1300
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1500</b>