
 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 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 deductible ?	For network providers and out-of-network providers \$1,300 individual / \$2,600 family	Generally, you must pay all of 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 deductible for specific services.
What is the out-of-pocket limit for this plan ?	For network providers \$3,000 individual / \$6,000 family; for out-of-network providers \$5,000 individual / \$10,000 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 ?	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 (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
		Network Provider (You will pay the least)	Out-of-Network Provider (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 copay */visit	30% coinsurance	None
	Specialist visit	\$20 copay */visit	30% coinsurance	None
	Preventive care/screening/immunization	No charge	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)	\$10 copay */visit	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	\$25 copay */visit	30% coinsurance	Preauthorization required: PET/CT scans, MRA, MRS, MRI, and nuclear cardiac imaging.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cvshealth.com	Generic drugs	copay */prescription: Retail: \$10 for 30 day, \$20 for 31-60 days, \$30 for 61-100 days; Mail order: \$10 for 30 days, \$20 for 31-100 days	\$10 copay plus 50% coinsurance of the remaining allowed amount and cost in excess of the maximum allowed amount	Covers up to a 100-day supply (retail or mail order prescription).
	Preferred brand drugs	copay */prescription: Retail: \$25 for 30 day, \$50 for 31-60 days, \$75 for 61-100 days; Mail order: \$25 for 30 days, \$50 for 31-100 days	\$30 copay plus 50% coinsurance of the remaining allowed amount and cost in excess of the maximum allowed amount	
	Non-preferred brand drugs	copay */prescription: Retail: \$25 for 30 day, \$50 for 31-60 days, \$75 for 61-100 days; Mail order: \$25 for 30 days, \$50 for 31-100 days	Not covered	Only covered if determined to be medically necessary through clinical review. Covers up to a 100-day supply (retail or mail order).
	Specialty drugs	See above limits	Not covered	Covers up to a 100-day supply (retail or mail order prescription).

For more information about limitations and exceptions, see the plan or policy document at www.umar.com.

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 copay */visit	30% coinsurance	None
	Physician/surgeon fees	Office: \$20 copay */visit. Other: no charge*	30% coinsurance	Preauthorization required
If you need immediate medical attention	Emergency room care	\$75 copay */visit	10% coinsurance	copay waived if admitted
	Emergency medical transportation	\$50 copay *	10% coinsurance	None
	Urgent care	\$20 copay */visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 copay */admission	30% coinsurance	Preauthorization required
	Physician/surgeon fees	No charge*	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Individual therapy: \$20 copay */visit. Group therapy: \$10 copay */visit	30% coinsurance	network providers : substance abuse group therapy: \$5 copay */visit
	Inpatient services	General hospital/private proprietary psychiatric facility/certified alcohol/substance use disorder facility: \$150 copay *. Partial hospitalization or intensive outpatient: no charge*	30% coinsurance	Preauthorization required. network providers : substance abuse partial hospitalization or intensive outpatient: \$5 copay */visit. network providers : transitional residential facility: \$50 copay *.
If you are pregnant	Office visits	No charge*	30% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	\$150 copay *	30% coinsurance	Depending on the type of services, Cost sharing may apply.

If you need help recovering or have other special health needs	Home health care	No charge*	30% coinsurance	Limited to 100 visits/year; 3 visits/person/day.
	Rehabilitation services	\$20 copay */visit	30% coinsurance	None
	Habilitation services			
	Skilled nursing care	\$200 copay */visit	30% coinsurance	Preauthorization required. Limited to 100 days/year
	Durable medical equipment	\$20 copay */visit	30% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
Hospice services	No charge*	30% coinsurance	Respite care: Limited to 5 consecutive days/admission.	
If your child needs dental or eye care	Children's eye exam	\$10 copay */visit	30% coinsurance	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](#).)

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|--|--|---|
| <ul style="list-style-type: none"> • Cosmetic Surgery • Dental Care • Infertility Treatment | <ul style="list-style-type: none"> • Long Term Care • Non-emergency care when traveling outside the U.S. unless travel is for the sole purpose of obtaining medical services | <ul style="list-style-type: none"> • Routine Foot Care • Weight Loss Programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none"> • Acupuncture (if prescribed for rehabilitation purposes) • Bariatric Surgery | <ul style="list-style-type: none"> • Chiropractic Care • Hearing Aids | <ul style="list-style-type: none"> • Private Duty Nursing (inpatient only) • Routine Eye Care (Adult) |
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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. 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: UMR Claims Appeal Unit, PO Box 30546, Salt Lake City, UT 84130-0546, 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 plan's overall deductible	\$1300
■ Specialist	\$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*)

Total Example Cost	\$13924
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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
The total Peg would pay is	\$1600

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1300
■ Specialist	\$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*)

Total Example Cost	\$7541
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1300
Copayments	\$1100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2420

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1300
■ Specialist	\$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*)

Total Example Cost	\$1925
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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
The total Mia would pay is	\$1500