



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 1-888-438-6105. 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 1-888-438-6105 to request a copy.

| Important Questions   | Answers   | Why this Matters:  |
|---|---|--|
| What is the overall <a href="#">deductible</a> ?                                | \$750 person / \$1,500 family SmartCare<br>\$1,250 person / \$2,500 family In 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> .  |
| 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?              | Yes. TMJ has a separate deductible.   | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$4,750 person / \$9,500 family SmartCare<br>\$5,250 person / \$10,500 family In Network<br>\$1,600 person Rx/\$3,200 family Rx   | 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="#">Copayments</a> for certain services, penalties, deductible for out-of-network charges, <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 1-888-438-6105 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 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 <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (a <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 <a href="#">referral</a> .   |



All [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  |
|--|--|--|--|---|---|
|  |  | SmartCare<br>(You will pay the least)      | In Network                                 | Out of Network<br>(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 Copay per visit;<br>Deductible Waived | \$35 Copay per visit;<br>Deductible Waived | Not covered                               | None  |
|  | <a href="#">Specialist</a> visit                         | \$40 Copay per visit;<br>Deductible Waived | \$55 Copay per visit;<br>Deductible Waived | Not covered                               | None  |
|  | <a href="#">Preventive care/ screening</a> /immunization | No charge;<br>Deductible Waived            | No charge;<br>Deductible Waived            | Not covered                               | 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   | <a href="#">Diagnostic test</a><br>(x-ray, blood work)   | 20% Coinsurance;<br>Deductible Waived      | 25% Coinsurance;<br>Deductible Waived      | Not covered                               | None  |
|  | Imaging<br>(CT/PET scans, MRIs)                          | \$50 Copay per visit;<br>20% Coinsurance   | \$100 Copay per visit;<br>25% Coinsurance  | Not covered                               | Preauthorization is required.   |

| Common Medical Event  | Services You May Need                            | What You Will Pay   |   |   | Limitations, Exceptions, & Other Important Information  |
|---|--|---|---|---|---|
|   |  | SmartCare<br>(You will pay the least)   | In Network  | Out of Network<br>(You will pay the most)   |   |
| <p>If you need drugs to treat your illness or condition.</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.medimpact.com">www.medimpact.com</a></p> | Tier 1   | \$15 Retail/Mail; one Copayment for each 30 day   | \$15 Retail/Mail; one Copayment for each 30 day   | \$20.00 Retail/Mail; one Copayment for each 30 day  | <p>Some drugs require Prior Authorization and others require Step Therapy or have quantity limits. Reference Based Pricing applies to some drugs. Please refer to your "Prescription Drug Program Summary of Benefits". Mail order up to 90 day supply on maintenance medicines. Specialty drugs applicable Copayment applies.</p> <p>OOP max does not include costs for excluded or non-covered medications or devices. Non covered medications do not go to the Rx Max OOP expense.</p> |
|   | Tier 2   | \$55 Retail/Mail; one Copayment for each 30 day   | \$55 Retail/Mail; one Copayment for each 30 day   | \$60.00 Retail/Mail; one Copayment for each 30 day  |   |
|   | Tier 3   | \$90 Retail/Mail; one Copayment for each 30 day   | \$90 Retail/Mail; one Copayment for each 30 day   | \$95.00 Retail/Mail; one Copayment for each 30 day  |   |
|   | <a href="#">Specialty drugs</a>                  | \$15 Tier 1<br>\$50 Tier 2<br>\$90 Tier 3   | \$15 Tier 1<br>\$50 Tier 2<br>\$90 Tier 3   | \$20.00 Tier 1<br>\$60.00 Tier 2<br>\$95.00 Tier 3  |   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | 20% Coinsurance   | \$150 Copay per visit;<br>25% Coinsurance   | Not covered   | Preauthorization is required.   |
|   | Physician/surgeon fees                           | 20% Coinsurance   | 25% Coinsurance   | Not covered   | None  |
| If you need immediate medical attention   | <a href="#">Emergency room care</a>              | \$150 Copay for 1 <sup>st</sup> visit;<br>\$200 Copay for 2 <sup>nd</sup> visit;<br>\$250 Copay for 3 <sup>rd</sup> & up visit of the calendar year;<br>Deductible Waived | \$150 Copay for 1 <sup>st</sup> visit;<br>\$200 Copay for 2 <sup>nd</sup> visit;<br>\$250 Copay for 3 <sup>rd</sup> & up visit of the calendar year;<br>Deductible Waived | \$150 Copay for 1 <sup>st</sup> visit;<br>\$200 Copay for 2 <sup>nd</sup> visit;<br>\$250 Copay for 3 <sup>rd</sup> & up visit of the calendar year;<br>Deductible Waived | Copay may be waived if admitted   |
|   | <a href="#">Emergency medical transportation</a> | \$100 Copay per occurrence;<br>Deductible Waived  | \$100 Copay per occurrence;<br>Deductible Waived  | \$100 Copay per occurrence;<br>Deductible Waived  | Copay may be waived if admitted   |
|   | <a href="#">Urgent care</a>                      | \$55 Copay per visit;<br>Deductible Waived  | \$55 Copay per visit;<br>Deductible Waived  | Not covered   | None  |

| Common Medical Event   | Services You May Need                     | What You Will Pay  |  |   | Limitations, Exceptions, & Other Important Information   |
|--|---|--|--|---|--|
|  |   | SmartCare<br>(You will pay the least)  | In Network   | Out of Network<br>(You will pay the most) |  |
| If you have a hospital stay  | Facility fee (e.g., hospital room)        | \$150 Copay per admission;<br>20% Coinsurance  | \$300 Copay per admission;<br>25% Coinsurance  | Not covered                               | Maximum combined Inpatient Copay per calendar year is \$1,200 per person, no more than one Copay per 30 calendar days; Preauthorization is required.   |
|  | Physician/surgeon fee                     | 20% Coinsurance  | 25% Coinsurance  | Not covered                               | None   |
| If you have mental health, behavioral health, or substance abuse needs | Outpatient services                       | \$20 Copay per visit;<br>Deductible Waived office visits; \$150 Copay per day for first 2 days;<br>20% Coinsurance Intensive Day Treatment;<br>20% Coinsurance other outpatient services | \$35 Copay per visit;<br>Deductible Waived office visits; \$150 Copay per day for first 2 days;<br>25% Coinsurance Intensive Day Treatment;<br>25% Coinsurance other outpatient services | Not covered                               | Preauthorization is required for Partial hospitalization.  |
|  | Inpatient services                        | \$150 Copay per admission;<br>20% Coinsurance  | \$300 Copay per admission;<br>25% Coinsurance  | Not covered                               | Maximum combined Inpatient Copay per calendar year is \$1,200 per person, no more than one Copay per 30 calendar days; Preauthorization is required.   |
| If you are pregnant  | Office visits                             | No charge;<br>Deductible Waived  | No charge;<br>Deductible Waived  | Not covered                               | Maximum combined Inpatient Copay per calendar year is \$1,200 per person, no more than one Copay per 30 calendar days; Copay waived after completion of Maternity Management Incentive. Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|  | Childbirth/delivery professional services | 20% Coinsurance  | 25% Coinsurance  | Not covered                               |  |
|  | Childbirth/delivery facility services     | No charge; Deductible Waived Delivery;<br>\$300 Copay per admission;<br>20% Coinsurance other inpatient services   | No charge; Deductible Waived Delivery;<br>\$300 Copay per admission;<br>25% Coinsurance other inpatient services   | Not covered                               |  |

| Common Medical Event   | Services You May Need                     | What You Will Pay                             |   |  | Limitations, Exceptions, & Other Important Information  |
|--|---|---|---|--|---|
|  |   | SmartCare<br>(You will pay the least)         | In Network                                    | Out of Network<br>(You will pay the most)  |   |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 20% Coinsurance                               | 25% Coinsurance                               | Not covered                                | 40 Maximum visits per calendar year;<br>Preauthorization is required.   |
|  | <a href="#">Rehabilitation services</a>   | 20% Coinsurance                               | 25% Coinsurance                               | Not covered                                | 30 Maximum visits per calendar year combined with Chiropractic care   |
|  | <a href="#">Habilitation services</a>     | Not covered                                   | Not covered                                   | Not covered                                | None  |
|  | <a href="#">Skilled nursing care</a>      | \$150 Copay per admission;<br>20% Coinsurance | \$300 Copay per admission;<br>25% Coinsurance | Not covered                                | Maximum combined Inpatient Copay per calendar year is \$1,200 per person, no more than one Copay per 30 calendar days;<br>Copay waived if transferred from an Acute Care Facility;<br>Preauthorization is required. |
|  | <a href="#">Durable medical equipment</a> | 20% Coinsurance                               | 25% Coinsurance                               | Not covered                                | Preauthorization is required.   |
|  | <a href="#">Hospice service</a>           | 20% Coinsurance                               | 25% Coinsurance                               | Not covered                                | None  |
| If you need dental or eye care                                 | Eye exam                                  | \$20 Copay per visit;<br>Deductible Waived    | \$35 Copay per visit;<br>Deductible Waived    | \$35 Copay per visit;<br>Deductible Waived | 1 Maximum exam per calendar year  |
|  | Glasses                                   | Not covered                                   | Not covered                                   | Not covered                                | None  |
|  | Dental check-up                           | Not covered                                   | 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
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- 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 (Tiers 1 & 2 only)
- Chiropractic care (Tiers 1 & 2 only)
- Hearing aids (Tiers 1 & 2 only)
- Non-emergency care when traveling outside the U.S.
- 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 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](#). Additionally, a consumer assistance program may help you file your [appeal](#). A list of states with Consumer Assistance Programs is available at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

### 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 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](#).

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

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](#) \$1,250
- [Specialist copayment](#) \$55
- Hospital (facility) [copayment](#) \$300
- Other [coinsurance](#) 25%

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>\$12,800</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,250        |
| Copayments                        | \$3,850        |
| Coinsurance                       | \$3,792        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,342</b> |

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

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist copayment](#) \$55
- Hospital (facility) [copayment](#) \$300
- Other [coinsurance](#) 25%

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>\$7,400</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles*                      | \$1,250        |
| Copayments                        | \$1,570        |
| Coinsurance                       | \$465          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$55           |
| <b>The total Joe would pay is</b> | <b>\$3,341</b> |

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

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist copayment](#) \$55
- Hospital (facility) [copayment](#) \$300
- Other [coinsurance](#) 25%

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic tests (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles*                      | \$1,138        |
| Copayments                        | \$305          |
| Coinsurance                       | \$354          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,797</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 1-888-438-6105.

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