

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. This SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of the 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, by calling 1-800-826-9781. For general definitions of common terms, such as allowance, balance billing, insurance payment, 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 <u>deductible</u> ?	\$1,500 person \$3,000 family In-network \$5,000 person \$10,000 family Out-network	Generally, you must pay all the costs from up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-benefits/
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$5,000 person \$10,000 family In-network \$7,500 person \$15,000 family Out-network	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members on the <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	Penalties, <u>premium</u> , <u>balance billing</u> charges, and health care that <u>this</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.umar.com or call 1-800-826-9781 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use a <u>network provider</u> and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your

All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if [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	20% Coinsurance	50% Coinsurance	None
	Specialist visit	20% Coinsurance	50% Coinsurance	None
	Preventive care/screening immunization	No charge; Deductible Waiver	50% 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)	20% Coinsurance	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance	None

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.caremark.com .	Generic drugs (Tier 1)	0% Coinsurance	Not Covered	None
	Preferred brand drugs (Tier 2)	20% Coinsurance	Not Covered	
	Nonpreferred brand drugs (Tier 3)	20% Coinsurance	Not Covered	

Common
Medical Even

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 excluded services .)		
Acupuncture	Infertility treatment	Private duty nursing
Cosmetic surgery	Long term care	Routine foot care
Dental care (Adult)	Non-emergency care when traveling outside the U.S.	Weight loss programs
	Urinary Drug Screenings (Out of Network for 2022)	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please [see your plan](#))

This is not a cost estimator. Treatments shown are just examples of how this [plan](#)