



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 1-800-362-1116. 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 1-800-362-1116 to request a copy.

| Important Questions   | Answers   | Why this Matters:   |
|---|---|---|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | <b>\$0</b> person / <b>\$0</b> family In-network<br><b>\$10,000</b> person / <b>Unlimited</b> 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>    | No.   | You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.   |
| <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> | <b>\$6,350</b> person / <b>\$12,700</b> family In-network<br><b>Unlimited</b> person / <b>Unlimited</b> 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>               | <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> .   |
| <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 1-800-362-1116 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<br>(You will pay the least)  | Out-of-network<br>(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       | \$15 Copay per visit  | 50% Coinsurance                           | None  |
|  | <a href="#">Specialist</a> visit                       | \$20 Copay per visit  | 50% Coinsurance                           | None  |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge   | 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                                     | <a href="#">Diagnostic test</a><br>(x-ray, blood work) | \$15 Copay per visit PCP;<br>\$20 Copay per visit Specialist<br>Office setting;<br>\$15 Copay per day Outpatient<br>setting | 50% Coinsurance                           | None  |
|  | Imaging<br>(CT/PET scans, MRIs)                        | \$15 Copay per visit PCP;<br>\$20 Copay per visit Specialist<br>Office setting;<br>\$25 Copay per day Outpatient<br>setting | 50% Coinsurance                           | None  |

| Common Medical Event   | Services You May Need                                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|--|---|--|--|--|
|  |   | In-network<br>(You will pay the least)   | Out-of-network<br>(You will pay the most)  |  |
| <p><b>If you need drugs to treat your illness or condition.</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.umar.com">www.umar.com</a>.</p> | Tier 1 (generic and some brand-name)                      | \$10 Copay per prescription (retail); \$20 Copay per prescription (mail order)                                   | <p>If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.</p> | <p>Out-of-pocket limit applies</p> <p>Covers up to a 34-day supply (retail); 35-90 day supply (mail order); Covers up to a 31-day supply (specialty)</p> <p>You must pay the difference in cost between a Generic drug and Brand-name drug when a medical professional has not specified a Brand-name drug or has not indicated that the Brand-name drug is necessary, this difference is not applied to preferred brand-name products in the high priced generic strategy, until the Out-of-pocket is met</p> |
|  | Tier 2 (preferred brand-name and some generic)            | \$25 Copay per prescription (retail); \$50 Copay per prescription (mail order)                                   |  |  |
|  | Tier 3 (nonpreferred brand-name and nonpreferred generic) | \$35 Copay per prescription (retail); \$70 Copay per prescription (mail order)                                   |  |  |
|  | Tier 4 ( <a href="#">specialty drugs</a> )                | \$20 Copay per prescription (Tier 1); \$50 Copay per prescription (Tier 2); \$70 Copay per prescription (Tier 3) |  |  |
| <p><b>If you have outpatient surgery</b></p>   | Facility fee (e.g., ambulatory surgery center)            | \$25 Copay per visit   | 50% Coinsurance  | None   |
|  | Physician/surgeon fees                                    | \$100 Copay per visit  | 50% Coinsurance  | None   |
| <p><b>If you need immediate medical attention</b></p>  | <a href="#">Emergency room care</a>                       | \$100 Copay per visit  | \$100 Copay per visit; Deductible Waived   | Copay may be waived if admitted  |
|  | <a href="#">Emergency medical transportation</a>          | No charge  | No charge  | None   |
|  | <a href="#">Urgent care</a>                               | \$50 Copay per visit   | 50% Coinsurance  | None   |

| Common Medical Event  | Services You May Need                     | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|---|---|---|---|--|
|   |   | In-network<br>(You will pay the least)                              | Out-of-network<br>(You will pay the most) |  |
| If you have a hospital stay   | Facility fee<br>(e.g., hospital room)     | \$150 Copay per admission   | 50% Coinsurance                           | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.  |
|   | Physician/surgeon fee                     | \$150 Copay per admission   | 50% Coinsurance                           |  |
| If you have mental health, behavioral health, or substance abuse services | Outpatient services                       | \$20 Copay per office visit;<br>No charge other outpatient services | 50% Coinsurance                           | None   |
|   | Inpatient services                        | \$150 Copay per admission   | 50% Coinsurance                           | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.  |
| If you are pregnant   | Office visits                             | No charge   | 50% Coinsurance                           | 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 | No charge   | 50% Coinsurance                           |  |
|   | Childbirth/delivery facility services     | \$150 Copay per admission   | 50% Coinsurance                           |  |

| Common Medical Event  | Services You May Need                     | What You Will Pay                      |   | Limitations, Exceptions, & Other Important Information  |
|---|---|--|---|---|
|   |   | In-network<br>(You will pay the least) | Out-of-network<br>(You will pay the most) |   |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | No charge                              | 50% Coinsurance                           | 120 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service. |
|   | <a href="#">Rehabilitation services</a>   | \$15 Copay per visit                   | 50% Coinsurance                           | 60 Maximum visits per calendar year   |
|   | <a href="#">Habilitation services</a>     | \$15 Copay per visit                   | 50% Coinsurance                           |   |
|   | <a href="#">Skilled nursing care</a>      | No charge                              | 50% Coinsurance                           | 60 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.    |
|   | <a href="#">Durable medical equipment</a> | No charge                              | 50% Coinsurance                           | Preauthorization is required for DME in excess of \$1,000. If you don't get preauthorization, benefits could be reduced by 25% per occurrence.                            |
|   | <a href="#">Hospice service</a>           | No charge                              | 50% Coinsurance                           | None  |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | Not covered                            | Not covered                               | None  |
|   | 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 <a href="#">Plan</a> Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |  |   |
|---|--|---|
| <ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul>  | <ul style="list-style-type: none"><li>• Hearing aids</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)  |  |   |
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Chiropractic care</li></ul>   | <ul style="list-style-type: none"><li>• Infertility treatment</li></ul>  | <ul style="list-style-type: none"><li>• Private-duty nursing</li></ul>  |

**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.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](#) \$0
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$200        |
| <a href="#">Coinsurance</a>       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Peg would pay is</b> | <b>\$200</b> |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles*</a>      | \$0          |
| <a href="#">Copayments</a>        | \$900        |
| <a href="#">Coinsurance</a>       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$20         |
| <b>The total Joe would pay is</b> | <b>\$920</b> |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles*</a>      | \$0          |
| <a href="#">Copayments</a>        | \$300        |
| <a href="#">Coinsurance</a>       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$300</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 1-800-362-1116.

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

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

**UMR: CITY OF PEMBROKE PINES: 7670-00-510020 001**

**Coverage Period:** 10/01/2023 – 9/30/2024

**Coverage for:** Individual + Family | **Plan Type:** PPO

The plan would be responsible for the other costs of these EXAMPLE covered services.