



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 by calling 1-800-207-3172. 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 or call 1-800-207-3172 to request a copy.

| Important Questions | Answers | Why this Matters: |
|--|---|---|
| What is the overall deductible? | \$3,450 person / \$6,900 person +1 / \$6,900 family In-network \$4,200 person / \$8,400 person +1 / \$8,400 family Out-of-network \$3,450 In-network / \$4,200 Out-of-network Maximum amount that any one person will satisfy toward the annual family deductible | Generally, you must pay all the costs from <u>providers</u> 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> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your deductible? | Yes. <u>Preventive care services</u> 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 <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> 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-care-benefits/ |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | \$6,800 person / \$13,600 person +1 / \$13,600 family In-network \$12,500 person / \$25,000 person +1 / \$25,000 family Out-of-network \$6,800 In-network / \$12,500 Out-of-network Maximum amount that any one person will satisfy toward the annual family out-of-pocket | 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 in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | Penalties, <u>premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a network provider? | Yes. See www.umar.com or call 1-800-207-3172 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 an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> 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 <u>provider</u> before you get services. |

| | | |
|--|-----|--|
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |
|--|-----|--|

 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 (You will pay the least) | Out-of-network (You will pay the most) | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | 25% Coinsurance | 50% Coinsurance | None |
| | <u>Specialist</u> visit | 25% Coinsurance | 50% Coinsurance | None |
| | <u>Preventive care/screening/immunization</u> | No charge; Deductible Waived | 50% Coinsurance | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 25% Coinsurance | 50% Coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 25% Coinsurance | 50% Coinsurance | <u>Preauthorization</u> is required for Advanced imaging, excluding basic CT & MRI. |

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|--|--|--|---|--|
| | | 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 . Specialty drug coverage is available at 888-318-0445. | Generic drugs (Tier 1) | 25% after deductible \$15 min/\$100 max (retail 30 day) \$37.50 min/\$250 max (mail order 90 day) | 50% coinsurance (retail) | None |
| | Preferred brand drugs (Tier 2) | 25% after deductible \$40 min/\$150 max (retail 30 day) \$100 min/\$375 max (mail order 90 day) | 50% coinsurance (retail) | |
| | Non-preferred brand drugs (Tier 3) | 25% after deductible \$80 min/\$200 max (retail 30 day) \$200 min/\$500 max (mail order 90 day) | 50% coinsurance (retail) | |
| | <u>Specialty drugs</u> (Tier 4) | Preferred Brands - 25% after deductible. \$40 min/\$150 max (30-day supply) Non-preferred brands - 25% after deductible. \$80 min/\$200 max (30-day supply) | No Coverage | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 25% Coinsurance | 50% Coinsurance | <u>Preauthorization</u> is required. |
| | Physician/surgeon fees | 25% Coinsurance | 50% Coinsurance | |
| If you need immediate | <u>Emergency room care</u> | 25% Coinsurance | 25% Coinsurance | In-network deductible applies to Out-of-network benefits |

| 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) | |
| medical attention | <u>Emergency medical transportation</u> | 25% Coinsurance | 25% Coinsurance | In-network deductible applies to Out-of-network benefits; <u>Preauthorization</u> is required for Non-emergent Air services. |
| | <u>Urgent care</u> | 25% Coinsurance | 50% Coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 25% Coinsurance | 50% Coinsurance | <u>Preauthorization</u> is required. |
| | Physician/surgeon fees | 25% Coinsurance | 50% Coinsurance | |
| If you have mental health, behavioral health, or substance abuse services | Outpatient services | 25% Coinsurance | 50% Coinsurance | <u>Preauthorization</u> is required for Partial hospitalization. |
| | Inpatient services | 25% Coinsurance | 50% Coinsurance | <u>Preauthorization</u> is required. |
| If you are pregnant | Office visits | No charge; Deductible Waived | 50% Coinsurance | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>deductible</u> , <u>copayment</u> or <u>coinsurance</u> may apply. Maternity |

| 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) | |
| | Childbirth/delivery professional services | 25% Coinsurance | 50% Coinsurance | care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery facility services | 25% Coinsurance | 50% Coinsurance | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 25% Coinsurance | 50% Coinsurance | 120 Maximum visits per calendar year combined with Private-duty nursing |
| | <u>Rehabilitation services</u> | 25% Coinsurance | 50% Coinsurance | 50 Maximum visits per calendar year OT; 50 Maximum visits per calendar year PT; 50 Maximum visits per calendar year ST |
| | <u>Habilitation services</u> | 25% Coinsurance | 50% Coinsurance | |
| | <u>Skilled nursing care</u> | 25% Coinsurance | 50% Coinsurance | 60 Maximum days per confinement; <u>Preauthorization</u> is required. |
| | <u>Durable medical equipment</u> | 25% Coinsurance | 50% Coinsurance | <u>Preauthorization</u> is required for DME in excess of \$500 for rentals or \$1,500 for purchases. |
| | <u>Hospice service</u> | 25% 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 your child needs dental or eye care | Children's eye exam | No charge; Deductible Waived | 50% Coinsurance | 1 Maximum exam per calendar year |
| | 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 Plan 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"> Dental care (Adult) Long-term care | <ul style="list-style-type: none"> Routine foot care | <ul style="list-style-type: none"> Weight loss programs |

| | | |
|---|---|---|
| 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"> Acupuncture (limitations apply) Bariatric surgery (In-network only) Chiropractic care | <ul style="list-style-type: none"> Cosmetic surgery (if medically necessary) Hearing aids - \$500 per ear per year Infertility treatment - \$10,000 per lifetime (In-network only) | <ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Private-duty nursing (Outpatient care) – 120 visits per calendar year combined with Home health care Routine eye care (Adult) – 1 exam per calendar year |

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. 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. 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 and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-207-3172.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-207-3172.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-207-3172.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-800-207-3172.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-207-3172.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-207-3172.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-207-3172.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-800-207-3172.

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

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

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 **\$3,450**
- Specialist coinsurance **25%**
- Hospital (facility) coinsurance **25%**
- Other coinsurance **25%**

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*)

Total Example Cost **\$12,700**

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$3,450 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$2,300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$5,820 |

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

- The plan's overall deductible **\$3,450**
- Specialist coinsurance **25%**
- Hospital (facility) coinsurance **25%**
- 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*)

Total Example Cost **\$5,600**

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,100 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$4,300 |
| The total Joe would pay is | \$5,400 |

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

- The plan's overall deductible **\$3,450**
- Specialist coinsurance **25%**
- Hospital (facility) coinsurance **25%**
- 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*)

Total Example Cost **\$2,800**

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$2,800 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$10 |
| The total Mia would pay is | \$2,810 |

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 or call 1-800-207-3172.