



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 <u>deductible</u>?	\$3,500 person / \$7,000 family In-network \$7,000 person / \$14,000 family Out-of-network \$3,500 In-network / \$7,000 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 <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 <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 <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>?	\$3,500 person / \$7,000 family In-network \$14,000 person / \$28,000 family Out-of-network \$3,500 In-network / \$14,000 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 <u>out-of-pocket limit</u>?	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 <u>network provider</u>?	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 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	No charge after deductible	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	No charge after deductible	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> waived	40% <u>coinsurance</u>	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)	No charge after deductible	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge after deductible	40% <u>coinsurance</u>	<u>Preauthorization</u> is required for Advanced imaging, excluding basic CT & MRI.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In network Provider (You will pay the least)	Out of network Provider (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)	No charge after deductible (retail & mail order)	Not Covered	Major medical deductible applies. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (specialty drugs). There is no charge for preventive drugs. Dispense as Written (DAW) provision applies. Specialty drugs must be obtained from the specialty pharmacy network. Certain medications may require your provider to submit a prior authorization.
	Preferred brand drugs (Tier 2)	No charge after deductible (retail & mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	No charge after deductible (retail & mail order)	Not Covered	
	Specialty drugs (Tier 4)	No charge after deductible (retail & mail order)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	40% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Physician/surgeon fees	No charge after deductible	40% coinsurance	
If you need immediate medical attention	<u>Emergency room care</u>	No charge after deductible	No charge after deductible	In-network <u>deductible</u> applies to Out-of-network benefits
	Emergency medical transportation	No charge after deductible	No charge after deductible	In-network deductible applies to Out-of-network benefits; Preauthorization is required for Non-emergent Air services.
	<u>Urgent care</u>	No charge after deductible	No charge after deductible	In-network <u>deductible</u> applies to Out-of-network benefits

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In network Provider (You will pay the least)	Out of network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	40% <u>coinsurance</u>	Preauthorization is required.
	Physician/surgeon fees	No charge after deductible	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	No charge Office visits; 40% <u>coinsurance</u> other outpatient services	In-network deductible applies to Out-of-network benefits Office visits; Preauthorization is required for Partial hospitalization.
	Inpatient services	No charge after deductible	40% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	No charge; <u>deductible</u> waived	40% <u>coinsurance</u>	Cost sharing 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 care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge after deductible	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge after deductible	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In network Provider (You will pay the least)	Out of network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge after deductible	40% <u>coinsurance</u>	100 visits per calendar year
	<u>Rehabilitation services</u>	No charge after deductible	40% <u>coinsurance</u>	None
	<u>Habilitation services</u>	No charge after deductible	40% <u>coinsurance</u>	<u>Habilitation services</u> for Learning Disabilities are not covered.
	Skilled nursing care	No charge after deductible	40% coinsurance	100 days per calendar year; Preauthorization is required.
	<u>Durable medical equipment</u>	No charge after deductible	40% <u>coinsurance</u>	<u>Preauthorization</u> is required for DME in excess of \$500 for rentals or \$1,500 for purchases.
	Hospice service	No charge after deductible	40% coinsurance Outpatient; \$500 Copay per admission; 40% coinsurance Inpatient	None
If your child needs dental or eye care	Children's eye exam	No charge; <u>deductible</u> waived	No charge; <u>deductible</u> waived	1 exam per calendar year to age 19; 1 exam up to \$130 per calendar year from age 19
	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.)

- | | | |
|-----------------------|--|------------------------|
| • Bariatric surgery | • 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 |

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

- | | | |
|---|---|---|
| • Acupuncture – 20 visits per calendar year (In-network only) | • Hearing aids – from age 18; \$2,500 every 3 years | • Routine eye care (Adult) – 1 exam per calendar year to age 19; 1 exam up to \$130 per calendar year from age 19 |
| • Chiropractic care – 20 visits 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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. 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 (Deutsch): Fer Hilf griege in Deutsch, 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, å'gang 1-800-207-3172.

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 <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist</u> coinsurance	0 %
■ Hospital (facility) <u>coinsurance</u>	0 %
■ Other <u>coinsurance</u>	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*)

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

In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$3,500

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist</u> coinsurance	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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	\$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	\$0
The total Joe would pay is	\$1,100

Mia's Simple Fracture

(in network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist</u> coinsurance	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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*)

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	\$0
The total Mia would pay is	\$2,800