



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 1-800-826-9781. 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 1-800-826-9781 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                 | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$1,900 person / \$3,800 family In-network<br>\$3,800 person / \$7,600 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> .                                                                                                                                                                                                               |
| 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?              | No.                                                                                                                                     | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$4,300 person / \$8,600 family In-network<br>\$8,600 person / \$17,200 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.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Penalties, <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 1-800-826-9781 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. |
| 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 [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 <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness        | \$25 Copay per visit;<br>20% Coinsurance | 40% Coinsurance                           | None                                                                                                                                                                                      |
|                                                                        | <a href="#">Specialist</a> visit                        | \$45 Copay per visit;<br>20% Coinsurance | 40% Coinsurance                           | None                                                                                                                                                                                      |
|                                                                        | <a href="#">Preventive care/screening/</a> immunization | No charge;<br>Deductible Waived          | 40% Coinsurance                           | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                                     | <a href="#">Diagnostic test</a><br>(x-ray, blood work)  | 20% Coinsurance                          | 40% Coinsurance                           | None                                                                                                                                                                                      |
|                                                                        | Imaging<br>(CT/PET scans, MRIs)                         | 20% Coinsurance                          | 40% 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)                       |                                                                                                                                                             |
| <b>If you need drugs to treat your illness or condition.</b><br><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> | Generic drugs (Tier 1)                           | Retail \$10<br>Mail Order \$25                                  | Retail \$10<br>Mail Order \$25                                  | Covers up to 30 days' supply (retail prescription), 31-90 days' supply (mail order prescription), Maximum day supply is 30 days for Specialty prescription. |
|                                                                                                                                                                                                            | Preferred brand drugs (Tier 2)                   | Retail \$40<br>Mail Order \$100                                 | Retail \$40<br>Mail Order \$100                                 |                                                                                                                                                             |
|                                                                                                                                                                                                            | Non-preferred brand drugs (Tier 3)               | Retail \$80<br>Mail Order \$200                                 | Retail \$80<br>Mail Order \$200                                 |                                                                                                                                                             |
|                                                                                                                                                                                                            | <u>Specialty drugs</u> (Tier 4)                  | 20% coinsurance, \$200 maximum per script                       | 20% coinsurance, \$200 maximum per script                       |                                                                                                                                                             |
| <b>If you have outpatient surgery</b>                                                                                                                                                                      | Facility fee (e.g., ambulatory surgery center)   | 20% Coinsurance                                                 | 40% Coinsurance                                                 | None                                                                                                                                                        |
|                                                                                                                                                                                                            | Physician/surgeon fees                           | 20% Coinsurance                                                 | 40% Coinsurance                                                 | None                                                                                                                                                        |
| <b>If you need immediate medical attention</b>                                                                                                                                                             | <a href="#">Emergency room care</a>              | \$250 Copay per visit;<br>20% Coinsurance;<br>Deductible Waived | \$250 Copay per visit;<br>20% Coinsurance;<br>Deductible Waived | Copay may be waived if admitted                                                                                                                             |
|                                                                                                                                                                                                            | <a href="#">Emergency medical transportation</a> | 20% Coinsurance                                                 | 20% Coinsurance                                                 | In-network deductible applies to Out-of-network benefits                                                                                                    |
|                                                                                                                                                                                                            | <a href="#">Urgent care</a>                      | \$35 Copay per visit;<br>20% Coinsurance;<br>Deductible Waived  | 40% 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)     | 20% Coinsurance                                                                                      | 40% Coinsurance                           | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service.                                                                                                                                                    |
|                                                                           | Physician/surgeon fees                    | 20% Coinsurance                                                                                      | 40% Coinsurance                           |                                                                                                                                                                                                                                                                                                                           |
| If you have mental health, behavioral health, or substance abuse services | Outpatient services                       | \$25 Copay per visit;<br>20% Coinsurance office visits;<br>20% Coinsurance other outpatient services | 40% Coinsurance                           | <a href="#">Preauthorization</a> is required for Partial <a href="#">hospitalization</a> . If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service.                                                                                                       |
|                                                                           | Inpatient services                        | 20% Coinsurance                                                                                      | 40% Coinsurance                           | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service.                                                                                                                                                    |
| If you are pregnant                                                       | Office visits                             | No charge;<br>Deductible Waived                                                                      | 40% Coinsurance                           | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">deductible</a> , <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services | 20% Coinsurance                                                                                      | 40% Coinsurance                           |                                                                                                                                                                                                                                                                                                                           |
|                                                                           | Childbirth/delivery facility services     | 20% Coinsurance                                                                                      | 40% 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>          | 20% Coinsurance                          | 40% Coinsurance                           | 100 Maximum visits per calendar year; <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service.         |
|                                                                       | <a href="#">Rehabilitation services</a>   | \$45 Copay per visit;<br>20% Coinsurance | 40% Coinsurance                           | 60 Maximum visits per calendar year OT;<br>60 Maximum visits per calendar year PT;<br>60 Maximum visits per calendar year ST;<br>Habilitation services for learning disabilities are not covered.                    |
|                                                                       | <a href="#">Habilitation services</a>     | \$45 Copay per visit;<br>20% Coinsurance | 40% Coinsurance                           |                                                                                                                                                                                                                      |
|                                                                       | <a href="#">Skilled nursing care</a>      | 20% Coinsurance                          | 40% Coinsurance                           | 60 Maximum days per calendar year; <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service.            |
|                                                                       | <a href="#">Durable medical equipment</a> | 20% Coinsurance                          | 40% Coinsurance                           | <a href="#">Preauthorization</a> is required for DME in excess of \$500 for rentals or \$1,500 for purchases. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 per occurrence. |
|                                                                       | <a href="#">Hospice service</a>           | 20% Coinsurance                          | 40% Coinsurance                           | None                                                                                                                                                                                                                 |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No charge;<br>Deductible Waived          | 40% Coinsurance                           | 1 Maximum exam every 24 months                                                                                                                                                                                       |
|                                                                       | 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>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>               | <ul style="list-style-type: none"><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 – 25 visits per calendar year</li></ul>                                                                 | <ul style="list-style-type: none"><li>• Hearing aids – to age 21; \$2,500 benefit every 48 months</li><li>• Infertility treatment</li></ul> | <ul style="list-style-type: none"><li>• Private-duty nursing (Inpatient care)</li><li>• Routine eye care (Adult) – 1 exam every 24 months</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://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 1-800-826-9781.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-826-9781.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-826-9781.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf die do Nummer uff 1-800-826-9781.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-826-9781.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-826-9781.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-826-9781.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,900 |
| ■ <a href="#">Specialist copayment</a>                          | \$45    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

#### 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>       | \$1,900        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$2,100        |
| What isn't covered                |                |
| Limits or exclusions              | \$70           |
| <b>The total Peg would pay is</b> | <b>\$4,070</b> |

### Managing Joe's Type 2 Diabetes

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,900 |
| ■ <a href="#">Specialist copayment</a>                          | \$45    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

#### 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>       | \$1,100        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$4,300        |
| <b>The total Joe would pay is</b> | <b>\$5,400</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,900 |
| ■ <a href="#">Specialist copayment</a>                          | \$45    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

#### 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>       | \$1,900        |
| <a href="#">Copayments</a>        | \$300          |
| <a href="#">Coinsurance</a>       | \$100          |
| What isn't covered                |                |
| Limits or exclusions              | \$10           |
| <b>The total Mia would pay is</b> | <b>\$2,310</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 1-800-826-9781.