



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> ?                                | \$1,650 person / \$3,300 family In-network<br>\$3,300 person / \$6,600 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> , the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.  |
| 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> ? | \$3,300 person / \$6,600 family In-network<br>\$6,600 person / \$13,200 family Out-of-network<br>\$3,300 In-network / \$6,600 Out-of-network<br>Maximum amount that any one person will satisfy toward the annual family out-of-pocket | 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        | 20% Coinsurance                        | 40% Coinsurance                           | None  |
|  | <a href="#">Specialist</a> visit                        | 20% Coinsurance                        | 40% Coinsurance                           | None  |
|  | <a href="#">Preventive care/screening/</a> immunization | No charge;<br>Deductible Waived        | Not covered                               | 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                           | <a href="#">Preauthorization</a> is required.   |

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|--|--|--|---|---|
|  |  | 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)                           | 20% Coinsurance                        | 20% Coinsurance                           | None  |
|  | Preferred brand drugs (Tier 2)                   | 20% Coinsurance                        | 20% Coinsurance                           |   |
|  | Non-preferred brand drugs (Tier 3)               | 20% Coinsurance                        | 20% Coinsurance                           |   |
|  | <a href="#">Specialty drugs</a> (Tier 4)         | 20% Coinsurance                        | 20% Coinsurance                           |   |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)   | 20% Coinsurance                        | 40% Coinsurance                           | <a href="#">Preauthorization</a> is required.   |
|  | Physician/surgeon fees                           | 20% Coinsurance                        | 40% Coinsurance                           |   |
| <b>If you need immediate medical attention</b>   | <a href="#">Emergency room care</a>              | 20% Coinsurance                        | 20% Coinsurance                           | In-network deductible applies to Out-of-network benefits  |
|  | <a href="#">Emergency medical transportation</a> | 20% Coinsurance                        | 20% Coinsurance                           | In-network deductible applies to Out-of-network benefits; <a href="#">Preauthorization</a> is required for Non-emergent Air services. |
|  | <a href="#">Urgent care</a>                      | 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) |   |
| If you have a hospital stay   | Facility fee<br>(e.g., hospital room)     | 20% Coinsurance                        | 40% Coinsurance                           | <a href="#">Preauthorization</a> is required.   |
|   | Physician/surgeon fees                    | 20% Coinsurance                        | 40% Coinsurance                           |   |
| If you have mental health, behavioral health, or substance abuse services | Outpatient services                       | 20% Coinsurance                        | 40% Coinsurance                           | <a href="#">Preauthorization</a> is required for Partial hospitalization.   |
|   | Inpatient services                        | 20% Coinsurance                        | 40% Coinsurance                           | <a href="#">Preauthorization</a> is required.   |
| 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="#">Rehabilitation services</a>   | 20% Coinsurance                        | 40% Coinsurance                           | None  |
|   | <a href="#">Habilitation services</a>     | 20% Coinsurance                        | 40% Coinsurance                           | Habilitation services for Learning Disabilities are not covered.  |
|   | <a href="#">Skilled nursing care</a>      | 20% Coinsurance                        | 40% Coinsurance                           | 100 Maximum days per calendar year; <a href="#">Preauthorization</a> is required.                             |
|   | <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. |
|   | <a href="#">Hospice service</a>           | 20% Coinsurance                        | 40% 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>• Infertility treatment</li><li>• Long-term care</li><li>• Private-duty nursing</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>• Hearing aids</li></ul>  | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.HealthCare.gov](http://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](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](#). 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](http://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](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](#).

### 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 (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-800-826-9781.

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

Samoaan (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, â'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> | \$1,650 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ 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>       | \$1,650        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,700        |
| What isn't covered                |                |
| Limits or exclusions              | \$70           |
| <b>The total Peg would pay is</b> | <b>\$3,370</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> | \$1,650 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ 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> | \$1,650 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ 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> *     | \$1,650        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$200          |
| What isn't covered                |                |
| Limits or exclusions              | \$10           |
| <b>The total Mia would pay is</b> | <b>\$1,860</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.

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