



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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0 person / \$0 family In-network \$400 person / \$800 family Out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the medical out-of-pocket for this plan?	\$1,000 person / \$2,000 family In-network \$2,000 person / \$4,000 family Out-of-network	Medical deductibles apply to the medical out-of-pocket for this plan
What is the pharmacy out-of-pocket for this plan?	\$5,600 person / \$11,200 family In-network Not covered Out-of-network	Pharmacy co-pays apply to the pharmacy out-of-pocket for this plan
What is the Maximum out-of-pocket limit for this plan?	\$6,600 person / \$13,200 family In-network \$7,600 person / \$15,200 family Out-of-network	The maximum out-of-pocket limit is the most you could pay in a year in deductibles, coinsurance and co-pays for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umar.com or call 1-800-826-9781 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider 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 referral 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	\$20 Copay per visit	30% Coinsurance	None
	<u>Specialist</u> visit	\$20 Copay per visit	30% Coinsurance	None
	Preventive care/ <u>screening</u> / <u>immunization</u>	No charge	30% 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 <u>test</u>	Diagnostic test (x-ray, blood work)	No charge	30% 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)	
<p>If you need drugs to treat your illness or condition.</p> <p>More information about prescription drug coverage is available at www.umr.com.</p>	Imaging (CT/PET scans, MRIs)	No charge Office setting; 10% Coinsurance Outpatient setting	30% Coinsurance	None
	Tier 1 (generic and some brand-name)	\$10 Copay per prescription	<p>If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.</p> <p>Once the annual out-of-pocket limit is met, you pay nothing for covered prescription medication</p>	<p>\$5,600 person / \$11,200 family annual Maximum out-of-pocket per calendar year</p> <p>Covers up to a 30-day supply (retail); 31-90 day supply (mail order); Covers up to a 30-day supply (specialty)</p>
	Tier 2 (preferred brand-name and some generic)	\$30 Copay per prescription		
	Tier 3 (nonpreferred brand-name and nonpreferred generic)	\$50 Copay per prescription		
Tier 4 (specialty drugs)	\$10 Copay per prescription (Tier 1); \$30 Copay per prescription (Tier 2); \$50 Copay per prescription (Tier 3)			
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	30% Coinsurance	None
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	None
<p>If you need immediate</p>	Emergency room care	10% Coinsurance	10% Coinsurance; Deductible Waived	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)	
medical attention	Emergency medical transportation	10% Coinsurance	10% Coinsurance; Deductible Waived	None
	Urgent care	10% Coinsurance	10% Coinsurance; Deductible Waived	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	30% Coinsurance	Preauthorization is required.
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	\$20 Copay per Office visit; 10% Coinsurance other outpatient services	30% Coinsurance	None
	Inpatient services	10% Coinsurance	30% Coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No charge	30% Coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may

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)	
<p>If you need help recovering or have other special health needs</p>	Childbirth/delivery professional services	10% Coinsurance	30% Coinsurance	<p>apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</p>
	Childbirth/delivery facility services	10% Coinsurance	30% Coinsurance	
	Home health care	10% Coinsurance	30% Coinsurance	
	Rehabilitation services	\$20 Copay per visit	30% Coinsurance	
	Habilitation services	\$20 Copay per visit	30% Coinsurance	
	Skilled nursing care	10% Coinsurance	30% Coinsurance	
	Durable medical equipment	10% Coinsurance	30% Coinsurance	<p>Preauthorization is required for DME in excess of \$500 for rentals or \$1,500 for purchases.</p>
	Hospice service	10% Coinsurance	10% Coinsurance; Deductible Waived	<p>None</p>

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	30% 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.)

- Acupuncture
- Hearing aids
- Cosmetic surgery
- Infertility treatment
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Private-duty nursing (Outpatient care)
- Routine eye care (Adult)
- Chiropractic care

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.ccoio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://www.healthcare.gov). For more information about the [Marketplace](http://www.healthcare.gov), 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://ecilio.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, kwijijigo 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.

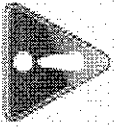
Samoa (Gagana Samoa): Mo se fescasoani i le Gagana Samoa, valatau mai i le numera telefoni 1-800-826-9781.

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

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, ágang 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 plan's overall deductible \$0
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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:

Cost Sharing	
Deductibles	\$0
Copayments	\$60
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$1,000

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

- The plan's overall deductible \$0
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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:

Cost Sharing	
Deductibles*	\$0
Copayments	\$1,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

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

- The plan's overall deductible \$0
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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:

Cost Sharing	
Deductibles*	\$0
Copayments	\$100
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$300

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 1-800-826-9781.

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

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