



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 1-855-858-6860. 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 1-855-858-6860 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$1,650 person / \$3,300 family Network Provider (Tier 1) & Out-of-network (Tier 3) \$0 person / \$0 family Health Investment Network (HIN) (Tier 2)	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>?	\$10,600 person / \$21,200 family	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 1-855-858-6860 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
		Tier 1	Tier 2	Tier 3	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	No charge	Not covered	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	No charge	Not covered	None
	<u>Preventive care / screening / immunization</u>	No charge; <u>deductible</u> waived	No charge	Not covered	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.
	Menopause Health and Wellness Program	Not covered	\$500 copay; <u>deductible</u> waived	Not covered	Service must be performed by Dr. Michelle Lin (My Family Doc) (702) 209-3590 3227 East Warm Springs Road, Building 23, Ste. 300 Las Vegas, Nevada 89120

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge; <u>deductible</u> waived labs at Quest & x-rays at Steinberg Diagnostic; 20% <u>coinsurance</u> office & outpatient setting	No charge at Steinberg Diagnostic Medical Imaging, Quest Diagnostics, & office setting; Not available at all other imaging or lab facilities	Not covered	Freestanding facilities: must use Steinberg Diagnostics Medical Imaging (SDMI) and Quest Diagnostics. All other freestanding facilities will be denied, unless SDMI and Quest are unable to perform the necessary test.
	Imaging (CT/PET scans, MRIs)	No charge; <u>deductible</u> waived at Steinberg Diagnostic; 20% <u>coinsurance</u> office & outpatient setting	No charge at Steinberg Diagnostic Medical Imaging & office setting; Not available at all other imaging facilities	Not covered	Freestanding facilities: must use Steinberg Diagnostics Medical Imaging (SDMI). All other freestanding facilities will be denied, unless SDMI is unable to perform the necessary test.
If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at lucyrx.com/ththhealth	Generic drugs (Tier 1)	Retail: \$15 <u>copay</u> (1–34-day supply) \$40 <u>copay</u> (35–90-day supply) Mail Order: 25% <u>coinsurance</u> to a maximum of \$500		Not covered	-Prescriptions filled at pharmacies other than THT's Exclusive Network Retail Pharmacies will incur per prescription choice fee in addition to applicable <u>copays</u> . At CVS/Walgreens, the choice fees are \$25 for Tier 1, \$32 for Tier 2, \$36 for Tier 3. At all other pharmacies, the choice fee is \$10. -If the generic cost of the medication is less than the <u>copay</u> , the individual will be responsible for that lesser amount. -Diabetic Supplies: includes syringes, needles, lancets, and test strips – limited to a quantity of 200 per 30-day supply.
	Preferred brand drugs (Tier 2)	Retail: 25% <u>coinsurance</u> to a maximum of \$100 (1–34-day supply); 25% <u>coinsurance</u> to a maximum of \$300 (35–90-day supply) Mail Order: 25% <u>coinsurance</u> to a maximum of \$500		Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: 40% <u>coinsurance</u> (1–34-day supply) 40% <u>coinsurance</u> (35–90-day supply) Mail Order: 40% <u>coinsurance</u>		Not covered	
	Formulary Diabetic Supplies and Insulin	Supplies: \$0 copay Insulin: 25% <u>coinsurance</u> to a maximum of \$20 (1–30-day supply) 25% <u>coinsurance</u> to a maximum of \$40 (31–60-day supply)		Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	
		25% <u>coinsurance</u> to a maximum of \$60 (61–90-day supply)			
	Generic asthma drugs (Tier 1)	\$15 <u>copay</u> (1–30-day supply) \$40 <u>copay</u> (31–90-day supply)		Not covered	
	Preferred brand asthma drugs (Tier 2)	25% <u>coinsurance</u> to a maximum of \$50 (1–30-day supply) 25% <u>coinsurance</u> to a maximum of \$100 (31–60-day supply) 25% <u>coinsurance</u> to a maximum of \$150 (61–90-day supply)		Not covered	
	Non-preferred brand asthma drugs (Tier 3)	40% <u>coinsurance</u> up to 90-day supply			
	<u>Specialty drugs</u> (Tier 4 and 5)	Generic & Preferred brand drugs: 25% <u>coinsurance</u> to a maximum of \$500. Non-Preferred brand: 40% <u>coinsurance</u>		Not covered	30-day supply maximum. Questions regarding specialty drugs visit www.ththealth.org/pharmacy
	Select compounded hormone replacement drugs for the Menopause Health and Wellness Program	20% <u>coinsurance</u>		Not covered	Must be prescribed by Dr. Michelle Lin (My Family Doc). (702) 209-3590 Prescription must be filled at Solutions Specialty Pharmacy located at 8579 S. Eastern Ave, Las Vegas, NV 89123 (702) 792-3777

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not available	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not available	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	15% <u>coinsurance</u> ; <u>deductible</u> waived	15% <u>coinsurance</u> ; <u>deductible</u> waived	15% <u>coinsurance</u> ; <u>deductible</u> waived	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Not available	20% <u>coinsurance</u>	Tier 1 <u>deductible</u> applies to Tier 3 benefits; <u>Preauthorization</u> is required for Non-emergent services.
	<u>Urgent care</u>	\$30 <u>copay</u> per office visit; <u>deductible</u> waived	Not available	\$30 <u>copay</u> per office visit; <u>deductible</u> waived	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not available	20% <u>coinsurance</u> if admitted from ER otherwise Not covered	<u>Preauthorization</u> is required.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not available	20% <u>coinsurance</u> if admitted from ER otherwise Not covered	
If you need mental health, behavioral health, or	Outpatient services	20% <u>coinsurance</u>	No charge office visits; Not available other outpatient services	Not covered	<u>Preauthorization</u> is required for Partial <u>hospitalization</u> & Intensive treatment.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	
substance abuse services	Inpatient services	20% <u>coinsurance</u>	Not available	20% <u>coinsurance</u> if admitted from ER otherwise Not covered	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	No charge; <u>deductible</u> waived	No charge	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>deductible</u> , <u>copayment</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not available	20% <u>coinsurance</u> if admitted from ER otherwise Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not available	20% <u>coinsurance</u> if admitted from ER otherwise Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not available	Not covered	60 visits per calendar year
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	No charge	Not covered	<u>Preauthorization</u> is required after 30 visits. <u>Habilitation services</u> for Learning Disabilities are not covered.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	No charge	Not covered	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not available	Not covered	60 days per calendar year; <u>Preauthorization</u> is required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	No charge	Not covered	<u>Preauthorization</u> is required for DME in excess of \$3,000 for rentals or purchases.
	<u>Hospice service</u>	20% <u>coinsurance</u>	Not available	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Cosmetic surgery• Dental care (Adult)• Infertility treatment	<ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S.• Private-duty nursing	<ul style="list-style-type: none">• Routine eye care (Adult)• Routine foot care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none">• Acupuncture – 20 visits per calendar year (Tier 1 only)• Bariatric surgery (BARInet only)	<ul style="list-style-type: none">• Chiropractic care (Tier 1 & 2 only)• Hearing aids – 1 per ear & 1 repair per ear every 3 years (Tier 2 only)	<ul style="list-style-type: none">• Weight loss programs – \$50 reimbursement per calendar year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

Does this plan Provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-858-6860.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-855-858-6860.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-858-6860.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf die do Nummer uff 1-855-858-6860.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-858-6860.

Samoaan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-858-6860.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-858-6860.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-855-858-6860.

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>	\$1,650
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,650
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,900
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$3,620

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>	\$1,650
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,650
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$100
The total Joe would pay is	\$1,950

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,650
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

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

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 1-855-858-6860.