



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:
<p>What is the overall deductible?</p>	<p>\$2,000 person / \$4,000 family In-network \$5,000 person / \$10,000 family Out-of-network</p>	<p>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, the overall family deductible must be met before the plan begins to pay.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care services are covered before you meet your deductible.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>\$3,000 person / \$6,000 family In-network \$10,000 person / \$20,000 family Out-of-network</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Penalties, premiums, balance billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.umar.com or call 1-800-826-9781 for a list of network providers.</p>	<p>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 out-of-network provider for some services (such as lab work). Check with your provider before you get services.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>



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 provider's office or clinic	Primary care visit to treat an injury or illness	No charge	30% Coinsurance	None
	Specialist visit	No charge	30% Coinsurance	None
	Preventive care/screening/immunization	No charge; Deductible Waived	30% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% Coinsurance	Preauthorization is required for MRI/MRA/PET scans.

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.optumrx.com or call 1.800.334.8134.</p>	Generic drugs (Tier 1)	\$10 Copay (Retail 1-31 DS) \$25 Copay (Retail 32-90 DS) \$25 Copay (Mail 1-90 DS)	Not Applicable	<p>Manufacturer Copay Assistance Program (MCAP): Some specialty medications may qualify for third-party copayment assistance programs which could lower your out of pocket costs for those products. For any such specialty medication where third party copayment assistance is used, you will not receive credit toward your maximum out of pocket or deductible for any copayment or co-insurance amounts that are applied to a manufacturer coupon or rebate. Your employer has elected to enroll in OptumRx's Copay Card Accumulator Adjustment program(s).</p> <p>Specialty Medications: Specialty medications are high-cost drugs that are often injected or infused and require special storage and monitoring. These medications must be obtained through OptumRX specialty pharmacy by calling OptumRX at 1.855.427.4682. Some exceptions apply. These medications are limited to a 30 day supply.</p>
	Preferred brand drugs (Tier 2)	\$35 Copay (Retail 1-31 DS) \$87.50 Copay (Retail 32-90 DS) \$87.50 Copay (Mail 1-90 DS)	Not Applicable	
	Non-preferred brand drugs (Tier 3)	\$60 Copay (Retail 1-31 DS) \$150 Copay (Retail 32-90 DS) \$150 Copay (Mail 1-90 DS)	Not Applicable	
	Specialty drugs (Tier 4)	\$10 Generic Copay Mail order (1-30DS) \$100 Preferred Brand Copay Mail order (1-30DS) \$300 Non-Preferred Brand Copay Mail order (1-30DS)	Not Applicable	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	No charge	30% Coinsurance	None
	Physician/surgeon fees	No charge	30% Coinsurance	None
	Emergency room care	No charge	No charge	In-network deductible applies to Out-of-network benefits

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 need immediate medical attention	Emergency medical transportation	No charge	No charge	In-network deductible applies to Out-of-network benefits
	Urgent care	No charge	30% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% Coinsurance	Preauthorization is required.
	Physician/surgeon fees	No charge	30% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	No charge	30% Coinsurance	Preauthorization is required for Partial hospitalization .
	Inpatient services	No charge	30% Coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No charge; Deductible Waived	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)	
	Childbirth/delivery professional services	No charge	30% Coinsurance	apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	No charge	30% Coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% Coinsurance	60 Maximum visits per calendar year; Preauthorization is required.
	Rehabilitation services	No charge	30% Coinsurance	None
	Habilitation services	No charge	30% Coinsurance	Habilitation services for Learning Disabilities are not covered.
	Skilled nursing care	No charge	30% Coinsurance	60 Maximum days per calendar year; Preauthorization is required.
	Durable medical equipment	No charge	30% Coinsurance	Preauthorization is required for DME in excess of \$1,500 for purchases or all rentals.
	Hospice service	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)	
If your child needs dental or eye care	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 Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery 	<ul style="list-style-type: none"> • Dental care (Adult) • Long-term care • Private-duty nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult) • 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.)		
<ul style="list-style-type: none"> • Chiropractic care • Hearing aids – \$2,500 per ear every 3 years 	<ul style="list-style-type: none"> • Infertility treatment – \$10,000 per lifetime 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#) or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance,

contact: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Additionally, a consumer assistance program may help you file your [appeal](#). A list of states with Consumer Assistance Programs is available at: www.HealthCare.gov and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

Does this plan Provide Minimum Essential Coverage? Yes

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

Does this plan Meet the Minimum Value Standard? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-826-9781.

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, 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 plan's overall deductible	\$2,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*pre-natal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist visit](#) (*anesthesia*)

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

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$2,070

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$2,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

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

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
The total Joe would pay is	\$5,400

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

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

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$2,010

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.