



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 ?	\$1,800 person / \$3,600 family In-network \$3,600 person / \$7,200 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 , the overall family deductible must be met before the plan begins to pay.
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 out-of-pocket limit for this plan ?	\$4,500 person / \$9,000 family In-network \$9,000 person / \$18,000 family Out-of-network	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.
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 out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



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	\$25 Copay per visit after deductible	30% Coinsurance	None
	Specialist visit	\$50 Copay per visit after deductible	30% Coinsurance	None
	Preventive care/screening/immunization	No charge; Deductible Waived	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	30% Coinsurance	Preauthorization is required for Advanced imaging, excluding basic CT & MRI.

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 drugs to treat your illness or condition. More information about prescription drug coverage is available at http://www.optumrx.com/ or call 1.800.334.8134.	Generic drugs (Tier 1)	After Deductible: \$10.00 Copay 1-30 Day Retail \$20.00 Copay 31-90 Day Retail (Maintenance Generic) \$20.00 Copay 1-90 Day Mail Order	Not covered	Generic Policy - Dispense As Written (DAW)- If you choose to buy the Brand name drug when a Generic equivalent is available, you will be required to pay the Brand copay/coinsurance plus the difference in cost between the Generic and Brand name drug. High Dollar Claim Review, Prior Authorization and Appeals program (HDCR)- Medication costs exceeding \$1,000 per 30-day supply and \$3,000 per 90-day supply require prior authorization. Low Clinical Value Drug List (LCV)- Separate formulary exclusion list including low clinical value drugs, me too/chemically similar drugs, new to market drugs, and non-essential. Maintenance Drug- Your plan allows maintenance medications to be filled in 90-day supplies by mail order pharmacy or at a retail pharmacy location. 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 coinsurance amounts that are applied to a manufacturer coupon or rebate. Your employer has elected to enroll in Optum's Copay Card Accumulator Adjustment program.
	Preferred brand drugs (Tier 2)	After Deductible: 20% Co-insurance (\$100.00 Maximum) 1-30 Day Retail 20% Co-insurance (\$200.00 Maximum) 31-90 Day Retail (Maintenance Preferred Brand Medications) 20% Co-insurance (\$200.00 Maximum) 1-90 Day Mail Order	Not covered	
	Non-preferred brand drugs (Tier 3)	After Deductible: 20% Co-insurance (\$200.00 Maximum) 1-30 Day Retail 20% Co-insurance (\$400.00 Maximum) 31-90 Day Retail (Maintenance Non-Preferred Brand Medications) 20% Co-insurance (\$400.00 Maximum) 1-90 Day Mail Order	Not covered	

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)	
	Specialty drugs (Tier 4)	After Deductible: Specialty 20% Coinsurance (\$300.00 Maximum) Mail Order 30 Day Specialty 20% Coinsurance (\$600.00 Maximum) Mail Order 90 Day	Not covered	Specialty Medications- 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	30% Coinsurance	Preauthorization is required.
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	
If you need immediate medical attention	Emergency room care	10% Coinsurance	10% Coinsurance	In-network deductible applies to Out-of-network benefits
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	In-network deductible applies to Out-of-network benefits; Preauthorization is required for Non-emergent Air services.
	Urgent care	\$50 Copay per visit after deductible	30% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 Copay per admission after deductible; 10% Coinsurance	\$100 Copay per admission after deductible; 30% Coinsurance	Preauthorization is required.
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	

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 have mental health, behavioral health, or substance abuse services	Outpatient services	\$25 Copay per visit after deductible; 10% Coinsurance office visits; 10% Coinsurance other outpatient services	30% Coinsurance	Preauthorization is required for Partial hospitalization.
	Inpatient services	\$100 Copay per admission after deductible; 10% Coinsurance	\$100 Copay per admission after deductible; 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 apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% Coinsurance	30% Coinsurance	
	Childbirth/delivery facility services	\$100 Copay per admission after deductible; 10% Coinsurance	\$100 Copay per admission after deductible; 30% Coinsurance	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	30% Coinsurance	100 Maximum visits per plan year
	Rehabilitation services	\$50 Copay per visit after deductible; 10% Coinsurance	30% Coinsurance	60 Maximum visits per plan year OT; 60 Maximum visits per plan year PT;

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)	
	Habilitation services	\$50 Copay per visit after deductible; 10% Coinsurance	30% Coinsurance	60 Maximum visits per plan year ST; Habilitation services for Learning Disabilities are not covered.
	Skilled nursing care	\$100 Copay per admission after deductible; 10% Coinsurance	\$100 Copay per admission after deductible; 30% Coinsurance	70 Maximum days per plan year; Preauthorization is required.
	Durable medical equipment	10% Coinsurance	30% Coinsurance	Preauthorization is required for DME in excess of \$500 for rentals or \$1,500 for purchases.
	Hospice service	10% Coinsurance	30% Coinsurance	100 Maximum visits per plan year
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	Not covered	1 Maximum exam per plan 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 | • Non-emergency care when traveling outside the U.S. |
| • Cosmetic surgery | • Infertility treatment | • Routine foot care |
| • Dental care (Adult) | • Long-term 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) – 1 exam per plan year (In-network only)
- Chiropractic care – 26 visits per plan 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 1-800-826-9781.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 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 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.

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	\$1,800
■ Specialist copayment	\$50
■ Hospital (facility) copayment	\$100
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,800
Copayments	\$100
Coinsurance	\$1,100
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$3,070

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,800
■ Specialist copayment	\$50
■ Hospital (facility) copayment	\$100
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,100
Copayments	\$0
Coinsurance	\$0
What isn't covered	
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	\$1,800
■ Specialist copayment	\$50
■ Hospital (facility) copayment	\$100
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,800
Copayments	\$400
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$2,310

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.