



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:
<b>What is the overall <a href="#">deductible</a>?</b>	\$1,650 person / \$3,300 family In-network \$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.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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>
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$4,125 person / \$8,250 family In-network \$8,250 person / \$16,500 family Out-of-network	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> , the overall family <a href="#">out-of-pocket limit</a> must be met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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 (You will pay the least)	Out-of-network (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 Copay per visit after deductible	30% Coinsurance	None
	<a href="#">Specialist</a> visit	\$50 Copay per visit after deductible	30% Coinsurance	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; 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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge after deductible	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge after deductible	30% Coinsurance	<a href="#">Preauthorization</a> is required.

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><b>If you need drugs to treat your illness or condition.</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> or call 1.800.334.8134.</p>	Generic drugs (Tier 1)	After Deductible: \$10 copay (retail 1-30 days) \$20 copay (retail 31-90 days) \$20 copay (mail 1-90 days)	Not Covered	<p><b>Generic Policy - Dispense As Written (DAW)</b> -If your doctor writes a prescription stating that a Generic may be dispensed, we will only pay for the Generic drug. If you choose to buy the Brand name drug in this situation, you will be required to pay the Brand copay/coinsurance plus the difference in cost between the Generic and Brand name drug. The Generic Policy does not apply if your doctor requires a brand name medication.</p> <p><b>High Dollar Claim Review, Prior Authorization and Appeals program (HDCR)</b> -Medication costs exceeding \$1,000 per 30-day supply and \$3,000 per 90-day supply require prior authorization.</p> <p><b>Low Clinical Value Drug List (LCV)</b> -Separate formulary exclusion list including low clinical value drugs, me too drugs, new to market drugs, and non-essential.</p> <p><b>Manufacturer Copay Assistance Program (MCAP)</b>-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><b>Maintenance Drug</b>-A medication that is used for chronic health conditions on an ongoing or long-</p>
	Preferred brand drugs (Tier 2)	After Deductible: 20% coinsurance (\$100.00 Maximum) (retail 1-30 days) 20% Co-insurance (\$200.00 Maximum) (retail 31-90 days) 20% Co-insurance (\$200.00 Maximum) (mail 1-90 days)	Not Covered	
	Non-preferred brand drugs (Tier 3)	After Deductible: 20% Co-insurance (\$200.00 Maximum). (retail 1-30 days) 20% Co-insurance (\$400.00 Maximum) (retail 31-90 days) 20% Co-insurance (\$400.00 Maximum) (mail 1-90 days)	Not Covered	
	<a href="#">Specialty drugs</a> (Tier 4)	After Deductible: 20% Co-insurance (\$300.00 Maximum) (retail 1-30 days) ***All Tiers***	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)	
				<p>term basis (e.g., antihypertensive medication taken daily to control high blood pressure).</p> <p><b>Specialty medications-</b> 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 1.800.850.9122. Some exceptions apply. These medications are limited to a 1–30-day supply.</p> <p><b>Step Therapy Program</b> -Certain medications may be subject to step therapy. You could be asked to try one of the first or second level options before certain drugs are covered by the plan</p>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	30% Coinsurance	None
	Physician/surgeon fees	No charge after deductible	30% Coinsurance	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 Copay per visit after deductible	\$200 Copay per visit after deductible	In-network deductible applies to Out-of-network benefits; Copay may be waived if admitted
	<a href="#">Emergency medical transportation</a>	No charge after deductible	No charge after deductible	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>	\$50 Copay per visit after deductible	\$50 Copay per visit after deductible; 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 you have a hospital stay	Facility fee (e.g., hospital room)	\$100 Copay per admission after deductible	\$100 Copay per admission after deductible; 30% Coinsurance	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	No charge after deductible	30% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	\$25 Copay per office visit after deductible; No charge other outpatient services	30% Coinsurance	<a href="#">Preauthorization</a> is required for Partial hospitalization.
	Inpatient services	\$100 Copay per admission after deductible	\$100 Copay per admission after deductible; 30% Coinsurance	<a href="#">Preauthorization</a> is required.
If you are pregnant	Office visits	No charge; Deductible Waived	30% 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	No charge after deductible	30% Coinsurance	
	Childbirth/delivery facility services	\$100 Copay per admission after deductible	\$100 Copay per admission after deductible; 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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge after deductible	30% Coinsurance	100 Maximum visits per plan year
	<a href="#">Rehabilitation services</a>	\$50 Copay per visit after deductible	30% Coinsurance	60 Maximum visits per plan year OT; 60 Maximum visits per plan year PT; 60 Maximum visits per plan year ST; Habilitation services for Learning Disabilities are not covered.
	<a href="#">Habilitation services</a>	\$50 Copay per visit after deductible	30% Coinsurance	
	<a href="#">Skilled nursing care</a>	\$100 Copay per admission after deductible	\$100 Copay per admission after deductible; 30% Coinsurance	70 Maximum days per plan year; <a href="#">Preauthorization</a> is required.
	<a href="#">Durable medical equipment</a>	No charge after deductible	30% 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>	No charge after deductible	30% Coinsurance	100 Maximum visits per plan year
<b>If your child needs dental or eye care</b>	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 <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>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Dental care (adult)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</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>• Bariatric surgery</li><li>• Chiropractic care – 26 visits per plan year</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing (Outpatient care)</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (adult) – 1 exam per plan year</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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](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](#). 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.

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](#) \$1,650
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$100
- 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

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,650
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$1,820</b>

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

- The [plan's](#) overall [deductible](#) \$1,650
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$100
- 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

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,100
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
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 [plan's](#) overall [deductible](#) \$1,650
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$100
- 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

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,650
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$2,060</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.