




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 1-866-868-6744. 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 1-866-868-6744 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Primary & Secondary Network: \$3,400 person / \$6,800 family \$3,400 Maximum that any one person will satisfy toward the annual family deductible Out-of-Network: No coverage unless otherwise listed	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 out-of-pocket limit for this plan?	Primary & Secondary Network: \$6,450 person / \$12,900 family \$6,450 Maximum that any one person will satisfy toward the annual family out-of-pocket Out-of-Network: No coverage unless otherwise listed	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 , 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 1-866-868-6744 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
		Primary Network: HonorHealth & Innovation Care Partners (ICP)	Secondary Network: UnitedHealthcare Choice Plus	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	Pediatrics: 20% Coinsurance; All other physicians: Not covered	Not covered	None
	Specialist visit	20% Coinsurance	Pediatrics Specialists & Perinatologists: 20% Coinsurance; All other physicians Not covered	Not covered	None
	Preventive care/screening/immunization	No charge; Deductible Waived	Pediatric Preventive screenings: No charge; Deductible Waived; All other physicians: Not covered Preventive screenings; Not covered Preventive care & Immunizations	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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Primary Network: HonorHealth & Innovation Care Partners (ICP)	Secondary Network: UnitedHealthcare Choice Plus	Out-of-Network	
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	Office setting & Outpatient setting: 20% Coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	Office setting & Outpatient setting: 20% Coinsurance	Not covered	Pre-certification is required for MRI/MRA and PET scans.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.optumrx.com	Generic drugs (Tier 1)	Retail Generic Preventive Drugs, 30-Day Supply: No charge after deductible Retail Generic Drugs, 30-Day Supply: \$15 co-payment after deductible Mail Generic Preventive Drugs, 90-Day Supply: No charge after deductible Walgreens Retail 90 Program and Mail Order Generic Drugs, 90-Day Supply: \$37.50 co-payment after deductible		Not Covered	Not all <u>prescription drugs</u> are covered. To determine if a specific drug is covered under your <u>plan</u> , log into your account at www.optumrx.com or call 1-844-368-9854. Your pharmacy benefit plan includes special coverage for preventive medications . These medications help protect against or manage medical conditions such as diabetes, hypertension, asthma, and depression. Prior authorizations, quantity limits and step therapy may apply to certain drugs. Dispense as Written (DAW) penalty: If you choose a brand drug when a generic equivalent drug is available you may pay the applicable brand copay or coinsurance plus the difference in cost between the brand drug and generic drug. The penalty does not
	Preferred brand drugs (Tier 2)	Retail Preferred Brand Drugs, 30-Day Supply: 35% co-insurance after deductible. Minimum: \$40, Maximum: \$100 Walgreens Retail 90 Program and Mail Order Preferred Brand Drugs, 90-Day Supply: 35% co-insurance after deductible Minimum: \$100, Maximum: \$250		Not Covered	
	Non-preferred brand drugs (Tier 3)	30-Day Supply: 60% co-insurance after deductible, Minimum: \$125 Walgreens Retail 90 Program and Mail Order Non-Preferred Brand Drugs, 90-Day Supply:		Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Primary Network: HonorHealth & Innovation Care Partners (ICP)	Secondary Network: UnitedHealthcare Choice Plus	Out-of-Network	
		Walgreens and Optum Mail: Participant pays 100% co-insurance after deductible at discounted cost			apply toward your <u>out-of-pocket limit</u> . If drug cost is less than co-payment, you pay just the drug cost.
	Specialty drugs (Tier 4)	30-Day Supply: Up to \$250 copay after deductible		Not Covered	Walgreens Retail 90 Program: 90-day maintenance medications will only be covered when filled at Walgreens retail pharmacy or OptumRx Mail Order. Maintenance medications are those you take regularly. <u>Specialty Drugs</u> are not covered unless obtained through OptumRx Specialty Pharmacy. Call 1-855-427-4682 or visit www.specialty.optumrx.com for prior approval. Some specialty drugs can be obtained through HonorHealth Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not covered	Not covered	Pre-certification is required.
	Physician/surgeon fees	20% Coinsurance	Not covered	Not covered	None
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	20% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Primary Network: HonorHealth & Innovation Care Partners (ICP)	Secondary Network: UnitedHealthcare Choice Plus	Out-of-Network	
	Urgent care	20% Coinsurance	20% Coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Emergency admissions: 20% Coinsurance; Non-emergency admissions: Not covered	Emergency admissions: 20% Coinsurance; Non-emergency admissions: Not covered	Pre-certification is required.
	Physician/surgeon fees	20% Coinsurance	Emergency admissions: 20% Coinsurance; Non-emergency admissions: Not covered	Emergency admissions: 20% Coinsurance; Non-emergency admissions: Not covered	Pre-certification is required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	20% Coinsurance	Not covered	Preauthorization is required for Partial hospitalization.
	Inpatient services	20% Coinsurance	20% Coinsurance	Not covered	Preauthorization is required.
If you are pregnant	Office visits	No charge; Deductible Waived	Certified nurse midwife & Lactation consultants: No charge; Deductible Waived; All other providers: Not covered	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).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Primary Network: HonorHealth & Innovation Care Partners (ICP)	Secondary Network: UnitedHealthcare Choice Plus	Out-of-Network	
	Childbirth/delivery professional services	20% Coinsurance	Not covered	Not covered	Pre-certification is required for breast pumps in excess of \$1,000.
	Childbirth/delivery facility services	20% Coinsurance	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	20% Coinsurance	Not covered	120 Maximum visits per calendar year Pre-certification is required.
	Rehabilitation services	20% Coinsurance	20% Coinsurance	Not covered	Habilitation services are covered only for Applied Behavior Analysis (ABA) Therapy for autism.
	Habilitation services	20% Coinsurance	20% Coinsurance	Not covered	
	Skilled nursing care	20% Coinsurance	20% Coinsurance	Not covered	120 Maximum days per calendar year Pre-certification is required.
	Durable medical equipment	20% Coinsurance	20% Coinsurance	Not covered	Pre-certification is required for durable medical equipment, including insulin pumps, in excess of \$1,000.
	Hospice service	20% Coinsurance	20% Coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Primary Network: HonorHealth & Innovation Care Partners (ICP)	Secondary Network: UnitedHealthcare Choice Plus	Out-of-Network	
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 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"> • Cosmetic surgery • Dental care (Adult) • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult) 	<ul style="list-style-type: none"> • 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"> • Acupuncture (Tier 1 & Tier 2 only) • Bariatric surgery (Tier 1 for employee & spouse/partner only) 	<ul style="list-style-type: none"> • Chiropractic care (Tier 1 & Tier 2 only) • Hearing aids (Tier 1 & Tier 2 only) 	<ul style="list-style-type: none"> • Infertility treatment (Tier 1 only)

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://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](#).

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	\$3,400
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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	
Deductibles	\$3,400
Copayments	\$0
Coinsurance	\$1,600
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$5,070

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$3,400
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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	
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	\$3,400
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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	
Deductibles*	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$2,810

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.umr.com or call 1-866-868-6744.

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