



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.umar.com](http://www.umar.com) or by calling 1-800-826-9781.

| Important Questions  | Answers  | Why this Matters:  |
|--|--|--|
| <b>What is the overall deductible?</b>                         | <p><b>\$2,000</b> person / <b>\$4,000</b> person + one / <b>\$5,000</b> family In-network</p> <p><b>\$2,000</b> person / <b>\$4,000</b> person + one / <b>\$5,000</b> family Out-of-network</p> <p>Copayments do not apply to the <b>deductible</b>.</p> | <p>You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b>.</p>  |
| <b>Are there other deductibles for specific services?</b>      | <p>No.</p>   | <p>You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</p>  |
| <b>Is there an out-of-pocket limit on my expenses?</b>         | <p>Yes. <b>\$5,000</b> person / <b>\$8,000</b> person + one / <b>\$10,000</b> family In-network</p> <p><b>\$5,000</b> person / <b>\$8,000</b> person + one / <b>\$10,000</b> family Out-of-network</p>   | <p>The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>  |
| <b>What is not included in the out-of-pocket limit?</b>        | <p>Copayments for medical services, penalties, premiums, balance-billed charges, and health care this plan doesn't cover.</p>  | <p>Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b>.</p>   |
| <b>Is there an overall annual limit on what the plan pays?</b> | <p>Yes. <b>\$2,250,000</b></p>   | <p>This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes <i>specific</i> coverage limits, such as limits on the number of office visits.</p>   |
| <b>Does this plan use a network of providers?</b>              | <p>Yes. For a list of <b>preferred providers</b>, see <a href="http://www.umar.com">www.umar.com</a>. Under the UnitedHealthcare Choice Plus Network. You may also call 1-800-826-9781.</p>  | <p>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the terms in-network, <b>preferred</b>, or participating for <b>providers</b> in their <b>network</b>. See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b>.</p> |

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|   |      |   |
|---|------|---|
| <b>Do I need a referral to see a <b>specialist</b>?</b> | No.  | You can see the <b>specialist</b> you choose without permission from this plan.   |
| <b>Are there services this plan doesn't cover?</b>      | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b> . |

-  **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event   | Services You May Need                            | Your cost if you use an |   | Limitations & Exceptions  |
|--|--|-------------------------|---|---|
|  |  | In-network              | Out-of-network                                    |   |
| <b>If you visit a health care <b>provider's</b> office or clinic</b> | Primary care visit to treat an injury or illness | 20% Coinsurance         | 40% Coinsurance                                   | ————— <b>none</b> —————   |
|  | Specialist visit                                 | 20% Coinsurance         | 40% Coinsurance                                   | ————— <b>none</b> —————   |
|  | Other practitioner office visit                  | 20% Coinsurance         | 40% Coinsurance                                   | ————— <b>none</b> —————   |
|  | Preventive care/screening/immunization           | No charge               | 40% Coinsurance; No charge Immunizations to age 6 | Deductible Waived In-network; Deductible Waived Out-of-network Immunizations to age 6 |
| <b>If you have a test</b>  | Diagnostic test (x-ray, blood work)              | 20% Coinsurance         | 40% Coinsurance                                   | ————— <b>none</b> —————   |
|  | Imaging (CT/PET scans, MRIs)                     | 20% Coinsurance         | 40% Coinsurance                                   | ————— <b>none</b> —————   |

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| Common Medical Event  | Services You May Need                          | Your cost if you use an   |   | Limitations & Exceptions  |
|---|--|---|---|---|
|   |  | In-network  | Out-of-network  |   |
| <b>If you need drugs to treat your illness or condition.</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.umar.com">www.umar.com</a> . | Generic drugs                                  | \$5 Copay per prescription  | If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount. | Covers up to a 34-day supply (retail and mail order); 35-90 day supply (mail order)<br><br>Deductible and out-of-pocket limit applies |
|   | Preferred brand drugs                          | \$25 Copay per prescription   |   |   |
|   | Non-preferred brand drugs                      | \$45 Copay per prescription   |   |   |
|   | Specialty drugs                                | \$5 Copay per prescription(generic); \$25 Copay per prescription(preferred brand); \$45 Copay per prescription(non-preferred brand) |   |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance   | 40% Coinsurance   | ————— <del>none</del> —————   |
|   | Physician/surgeon fees                         | 20% Coinsurance   | 40% Coinsurance   | ————— <del>none</del> —————   |
| <b>If you need immediate medical attention</b>  | Emergency room services                        | 20% Coinsurance   | 20% Coinsurance   | Deductibles apply. In-network deductible applies to Out-of-network benefits   |
|   | Emergency medical transportation               | No charge   | No charge   | In-network deductible applies to Out-of-network benefits; \$25,000 Maximum benefit per occurrence Ambulance air                       |
|   | Urgent care                                    | 20% Coinsurance   | 40% Coinsurance   | ————— <del>none</del> —————   |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)             | 20% Coinsurance   | 40% Coinsurance   | Prior authorization is required or benefit reduces by 20% to a maximum of \$100 per claim Out-of-network                              |
|   | Physician/surgeon fee                          | 20% Coinsurance   | 40% Coinsurance   | ————— <del>none</del> —————   |

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| Common Medical Event  | Services You May Need                        | Your cost if you use an                          |                 | Limitations & Exceptions   |
|---|--|--|-----------------|--|
|   |  | In-network                                       | Out-of-network  |  |
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services | 20% Coinsurance                                  | 40% Coinsurance | —————none—————   |
|   | Mental/Behavioral health inpatient services  | 20% Coinsurance                                  | 40% Coinsurance | Prior authorization is required or benefit reduces by 20% to a maximum of \$100 per claim Out-of-network   |
|   | Substance use disorder outpatient services   | 20% Coinsurance                                  | 40% Coinsurance | —————none—————   |
|   | Substance use disorder inpatient services    | 20% Coinsurance                                  | 40% Coinsurance | Prior authorization is required or benefit reduces by 20% to a maximum of \$100 per claim Out-of-network   |
| <b>If you are pregnant</b>  | Prenatal and postnatal care                  | No charge Prenatal;<br>20% Coinsurance Postnatal | 40% Coinsurance | Deductible Waived In-network Prenatal  |
|   | Delivery and all inpatient services          | 20% Coinsurance                                  | 40% Coinsurance | —————none—————   |
| <b>If you need help recovering or have other special health needs</b>         | Home health care                             | 20% Coinsurance                                  | 40% Coinsurance | 40 Maximum visits per calendar year; Prior authorization is required or benefit reduces by 20% to a maximum of \$100 per claim Out-of-network  |
|   | Rehabilitation services                      | 20% Coinsurance                                  | 40% Coinsurance | —————none—————   |
|   | Habilitation services                        | Not covered                                      | Not covered     | —————none—————   |
|   | Skilled nursing care                         | 20% Coinsurance                                  | 40% Coinsurance | First 30 days Maximum per confinement; there must be a 180 day separation between confinements, before an additional 90 days are covered per confinement; Prior authorization is required or benefit reduces by 20% to a maximum of \$100 per claim Out-of-network |
|   | Durable medical equipment                    | 20% Coinsurance                                  | 40% Coinsurance | Prior authorization is required for DME in excess of \$500 for rentals or \$1,500 for purchases or benefit reduces by 20% to a maximum of \$100 per claim Out-of-network   |
|   | Hospice service                              | 20% Coinsurance                                  | 40% Coinsurance | —————none—————   |

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| Common Medical Event                          | Services You May Need | Your cost if you use an |                 | Limitations & Exceptions   |
|---|-----------------------|-------------------------|-----------------|--|
|   |                       | In-network              | Out-of-network  |  |
| <b>If your child needs dental or eye care</b> | Eye exam              | No charge               | 40% Coinsurance | Deductible Waived In-network;<br>2 Maximum exams per calendar year |
|   | Glasses               | Not covered             | Not covered     | —————none—————   |
|   | Dental check-up       | Not covered             | Not covered     | —————none—————   |

**Excluded Services & Other Covered Services:**

| <b>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)</b>                                 |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (adult)</li> <li>• Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |

| <b>Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)</b>      |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Acupuncture for anesthesia or pain control</li> <li>• Hearing aids (Dependents under age 18)</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Routine eye care</li> </ul> | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> |

**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-826-9781. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <http://www.dol.gov/ebsa/>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

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### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: UMR at 1-800-826-9781. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

欲将该文件翻译成中文，请联系您的雇主。

Dii naaltsos Dine k'eh saadji'go haadldool nilgo, ei t'aasho'odi ba nainshigii  
bii hodoinh.

Si necesita este documento traducido al español, comuníquese con su empleador.

Upang ipa-translate ang dokumentong ito sa Tagalog, mangyaring makipag-ugnay sa iyong employer.

This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,600
- Patient pays \$2,940

Sample care costs:

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$2,000        |
| Copays               | \$40           |
| Coinsurance          | \$900          |
| Limits or exclusions | \$0            |
| <b>Total</b>         | <b>\$2,940</b> |

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,900
- Patient pays \$1,500

Sample care costs:

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$1,100        |
| Copays               | \$400          |
| Coinsurance          | \$0            |
| Limits or exclusions | \$0            |
| <b>Total</b>         | <b>\$1,500</b> |

## Questions and answers about Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Costs are based on individual coverage benefit levels.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- Prescription drug costs (Prescriptions) shown in the Coverage Examples reflect information provided by the Plan's Prescription Benefits Manager.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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