UMR A UnitedHealthcare Company

EAH PPO Plan with HRA

Coverage For: Family | Plan Type: PPO

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, call 1-800-207-3172 or visit member.umr.com. 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.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$3,000** Individual / **$6,000** Family Out-of-Network: **$9,000** Individual / **$18,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If youhave 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 is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual 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 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 thisplan?	Network: **$5,000** Individual / **$10,000** Family Out-of-Network: **$15,000** Individual / **$30,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have otherfamily membersinthisplan,theyhave tomeettheirownout-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	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 member.umr.com or call 1-800-207-3172 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 useanout-of-networkproviderforsome 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
		Network Provider (You will pay the least)	Out-of-Network Provider (Youwillpaythemost)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Virtual Visits - 0% coinsurance by a Designated Virtual Network Provider. No virtual coverage out-of-network.
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/ screening/ immunization	No Charge	Not covered	You may have to pay for services that aren't preventive. Ask yourproviderifthe servicesneededarepreventive. Then check what your plan will pay for. No coverage out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Lab Testing: Not Covered X-Ray/Diagnostics: 50% coinsurance	Preauthorization is required out-of-network for certain services or a $1,000 penalty applies. No coverage out-of-network for lab testing.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or a $1,000 penalty applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (Youwillpaythemost)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at smithrx.com	Tier 1 - Your Lowest Cost Option	Retail: $10 copay Mail-Order: $25 copay Specialty Retail: $10 copay	Retail: $10 copay Specialty Retail: $10 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy. Specialty drugs are not covered through mail-order You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s)prior to benefits under your policy being available for certain prescribed drugs. Prescription drug costs are subject to the annual deductible. Network deductible will be applied to the out-of-network provider and applies to the Network out-of-pocket limit.
	Tier2 - Your Mid-Range Cost Option	Retail: $35 copay Mail-Order: $87.50 copay Specialty Retail: $150 copay	Retail: $35 copay Specialty Retail: $150 copay	
	Tier3 - Your Mid-Range Cost Option	Retail: $70 copay Mail-Order: $175 copay Specialty Retail: $250 copay	Retail: $70 copay Specialty Retail: $250 copay	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Out-of-network allowed amounts for Facility Fees are limited to $760 per date of service. Preauthorization is required out-of-network for certain services or a $1,000 penalty applies.
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (Youwillpaythemost)	
If you need immediate medical attention	Emergency room care	20% coinsurance	*20% coinsurance	*Network deductible applies.
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network deductible applies.
	Urgent Care	20% coinsurance	50% coinsurance	Virtual Visits - 0% coinsurance by a Designated Virtual Network Provider. No virtual coverage out-of-network.
Ifyouhavea hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or no coverage
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance Preauthorization is required out-of-network for certain services or no coverage See your policy or plan document for additional information about EAP benefits.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or no coverage See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No Charge	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or no coverage

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (Youwillpaythemost)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 100 visits percalendar year. Out-of-network allowed amounts for Home health care are limited to $150 per visit. Preauthorization is required out-of-network or a $1,000 penalty applies.
	Rehabilitation services	20% coinsurance	50% coinsurance	Outpatient rehabilitation services are unlimited per calendar year. No limits apply for treatment of Autism Spectrum Disorder Services. No coverage out-of-network for physical and occupational therapy.
	Habilitative services	20% coinsurance	50% coinsurance	Services are provided under Rehabilitation Services above. No limits apply for treatment of Autism Spectrum Disorder Services. No coverage out-of-network for physical and occupational therapy.
	Skilled nursing care	20% coinsurance	50% coinsurance	Skilled nursing is Limited to 100 days per calendar year. Preauthorization is required out-of-network or a $1,000 penalty applies.
	Durable medical equipment	20% coinsurance	Not covered	No coverage out-of-network.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or a $1,000 penalty applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (Youwillpaythemost)	
If your child needs dentaloreyecare	Children's eye exam	20% coinsurance	Not covered	Limited to 1 exam every 24 months. No coverage out-of-network.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care
- Glasses
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside - the US
- Private duty nursing
- Routine foot care - Except as covered for Diabetes

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture- 20 visits per calendar year
- Bariatric surgery
- Chiropractic (manipulative) care - 24 visits per calendar year
- Hearing aids - $2,500 per calendar year
- Routine Eye Care - 1 Exam per24 months
- Weight loss programs- Real Appeal

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: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov , or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform . 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 on how 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: the Member Service number listed on the back of your ID card or member.umr.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov.

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 Standards? 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 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

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

* For more information about limitations and exceptions, see the plan or policy document at member.umr.com.

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	$3,000
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
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$10
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,670**

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

The plan's overall deductible	$3,000
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
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$400
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,470**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

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PAUNA\VA: Kungnagsasalita ka ng Tagalog (Tagalog), may makukuha kang mgalibreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

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ATANSYON:Si w pale **Kreyol ayisyen (Haitian Creole),** ou kapab benefisye sevis ki gratis pou ede w nan lang paw. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION: Si vous parlez **franc;ais (French),** des services d'aidelinguistique vous sont proposes gratuitement. Veuillez appeler le numero sans frais figurant dans ce Sommaire des prestations et dela couverture (Summary of Benefits and Coverage, SBC).

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ATEN<;:AO:Se voce fala portugues (Portuguese), contate o servic;o deassistencia deidiomas gratuito. Ligue para o numero gratuito listado neste Resumo de Beneficios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE:in caso la lingua parlata sia **l'italiano (Italian),** sono disponibili servizi di assistenza linguistica gratuiti. Chiamate ii numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfugung. Bitterufen Sie die in dieser Zusammenfassung der Leistungen und Kostenubernahmen (Summary of Benefits and Coverage, SBC) angegebene gebuhrenfreie Rufnummer an.

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PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu t.awagan nga numero nga nakalist.a iti uneg na daytoynga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

Dfi BAA'AKONINIZIN: **Dine (Navajo)** bizaad bee yanilti'go, saad bee aka'anida'awo'igii, t'aa jiik'eh, bee na'ah66t'i'. Taa shqqdi Naaltsoos Bee 'Aa'ahayani d66 Bee 'Ak'e'asti' Bee Baa Hane'i (Summary of Benefits and Coverage, SBC) biyi' t'aa jiik'ehgo beesh bee hane'i bika'igii bee hodiilnih.

OGO\.V: Haddii aad ku hadasho **Soomaali (Somali),** adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

English

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in your language, first call your insurance company's phone number at 1-800-842-2656. Someone who speaks your language can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

Español

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su compañía de seguros. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su compañía de seguros al 1-800-842-2656.
Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame a la línea directa del Departamento de seguros al 1-800-927-4357. (Spanish)

中文

重要事項：您與您的醫生或醫療保險公司交談時，可獲得免費口譯服務。 如欲請翻譯員提供口譯，或欲查詢中文書面資料，請先致電您的保險 公司，電話號碼 1-800-842-2656
說中文人士將為您提供協助。如需更多協助，請致電保險部熱線 1-800-927-4357(Chinese)

PCA394497-001

XIN LUU Y:N6u quyvj n6i ti6ng **Vi t(Vietnamese),** quyvj seduqccung c p djch v1,1rq giup v6ngon ngfrmi6nphi. Vui long g9is6 di n tho-1-i mi6nphi &m t sauthehc:;,i vien cua quyvj.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAVvA:Kung nagsasalita ka ng **Tagalog (Tagalog),** may makukuha kangmga libreng serbisyo ng tulongsa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

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تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

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وجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

t...:rr.=r : **(Hindi) gft:l''tr ,fi l:tlc1i : 34(4¢1f** 4 i:.llo1cr:rtrr cTI>r-1$1'J:i;).:;.t.fr qr q:;rn,rt I

CEEB TOOM: Yog koj **haisLusHmoob (Hmong),** muaj kevpab txhais luspub dawb rau koj. Thovhu rau tusxovtooj hu debdawb uas teevmuaj nyob rau ntawmkoj daim yuaj cim qhia tus kheej.

tirtmillfll1;!n.fi: illN2ijfi2t15l tilffi **fullg1(Khmer-Cambodian)** 1tun tilffiful1itltillifi ffi mfl2 flmtlijfi'"I l NQ1ITT1ru81ifi ffi 1iiMfl 21211rimp*N*@ Mu U:l)ruftl'ijn'1

fi1'tU').f'fi1'.lo'8fiJ-,.'L,'tph **h1111hphh(Armenian)** hp)ununuf, wuqlwp thqqwqwuoquntpJwu&wnwJnlpJntuuhp hu hwuunuf Qhq: Iuu11pqnuf I; qwuqwhwpht wuqlwp hhnw)unuwhwtfwpnq, npJ!u2'1,ht I; Qhp lwuw llll.wqwu pwpU1li,qpw:

ra§': i/i:r,:ft (Punjabi) '3i's"'I:I- Fkl' fe3, A • ; j),j8§!8 001fcral.r'craa -1.f3.3' 1B3o1E •1wgcra1

'hl Gl\11 11J: v11nqru.VjGlll1U-1"h1t1 (Thai) jj1J n, A11lJ'li1 tJLlifi.iGf1,u111:n tlfu.riqru.'iGlavl

q r u .'m i .i" LAaFi, t i:i, au.Iii.ici,,,tGi 'i tl Gl'iVl Pi'vi Vlii'3lilJ1 t1LE111'i Vl V VI.i tj1Ju11m tl :::i,m111.i"q ru.