

Teammate Benefits Plans

IN-NETWORK MEDICAL BENEFITS	BLUE PLAN	BRONZE PLAN		
Network	UnitedHealthcare Options PPO	UnitedHealthcare Choice Plus		
Calendar Year Deductible (Individual / Family)	\$0/\$0	\$3,000 / \$6,000		
Maximum Calendar Year Out of Pocket (Individual / Family)	N / A	\$6,000 / \$12,000		
PROFESSIONAL SERVICES	YOUR RESPONSIBILITY IS:	YOUR RESPONSIBILITY IS:		
Primary Care Visits	\$5 Copay, first 2 visits, \$25 Copay, visits 3 to 6	\$5 Copay, first 2 visits, \$25 Copay, visits 3+		
Specialist Visits	\$50 Copay, up to 4 visits per year	\$50 Copay		
Urgent Care	\$25 Copay, up to 4 visits per year	\$50 Copay		
Preventative Services	Covered 100%	Covered 100%		
Teledoctor	\$0 Copay	\$0 Copay		
	FIXED DOLLAR REIMBURSEMENT	DEDUCTIBLE AMOUNT		
X-RAY / LAB	PLAN WILL COVER UP TO:	YOUR RESPONSIBILITY IS:		
X-ray Services	\$1,000 up to 5 per year	Deductible then 20%		
Laboratory Services	\$500 up to 12 per year	Deductible then 20%		
Magnetic Resonance Imaging (MRI)	\$1,600 up to 1 per year	Deductible then 20%		
Computerized Tomography (CT) Scan	\$1,500 up to 1 per year	Deductible then 20%		
INPATIENT/OUTPATIENT BENEFITS	PLAN WILL COVER UP TO:	YOUR RESPONSIBILITY IS:		
Inpatient Hospital Services, Including Childbirth	\$3,000 up to 3 days	Deductible then 20%		
Outpatient Surgery	\$2,000 up to 2 per year	Deductible then 20%		
Anesthesia Services	\$2,000 up to 5 per year	Deductible then 20%		
Mental Health Benefit	\$500 up to 24 per year	Deductible then 20%		
Alcohol and Substance Abuse Benefit	\$500 up to 24 per year	Deductible then 20%		
Inpatient / Outpatient Doctor Benefit	\$125 up to 10 per year	Deductible then 20%		
EMERGENCY ROOM VISIT	PLAN WILL COVER UP TO:	PLAN WILL COVER UP TO:		
Treatment of an Accidental Injury	\$500 up to 2 per year	\$500 Copay, then Deductible + 20%		
Treatment of a Sickness	\$50 up to 1 per year	N / A		
PRESCRIPTION DRUGS	YOUR RESPONSIBILITY IS:	Retail (30 days)	Mail Order (90 days)	
Generic	\$5 Copay	\$15 Copay	\$30 Copay	
Preferred Brand	N / A	30%, minimum \$35	30%, minimum \$70	
Non-Preferred Brand	N / A	40%, minimum \$70	40%, minimum \$150	
PLAN RATES	Teammate Weekly Cost	Payrate: \$10 - \$14.99	Payrate: \$15 - \$16.99	Payrate: \$17+
Teammate Only	\$17.82	\$25.17	\$37.76	\$42.79
Teammate & Spouse	\$46.38	\$140.01	\$153.69	\$159.16
Teammate & Children	\$56.46	\$112.78	\$126.46	\$131.93
Family	\$80.69	\$258.93	\$272.61	\$278.08

The benefits outlined here are for **IN NETWORK** benefits only. You **MUST** be sure to confirm the provider or facility you choose participates in the network before you visit. The MEC plan does not cover out of network providers or facilities. If you choose to use an out of network provider you will be responsible for the full cost of the service or visit.

Finding a Provider

- Visit [umar.com](https://www.umar.com) and select "Find a provider"
- Scroll to "UnitedHealthcare Options PPO Network" or "UnitedHealthcare Choice Plus" in the alphabetical list, or type it into the search box
- For medical providers, choose "View Providers"
- For behavioral health providers, select "Behavioral Health Directory"

For assistance with any benefits questions, claims, and billing inquiries, please call the **Teammate Benefits Line** at: [1-833-236-7463](tel:1-833-236-7463)