


Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services


Coverage for: Employee/Family | Plan Type: EPO



NY G FRDM NG 15/35/1750/90 EPO 26

 **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.whyuhc.com](http://www.whyuhc.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](http://www.healthcare.gov/sbc-glossary) or call 1-800-444-6222 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Network: \$1,750 Individual / \$3,500 Family Per Contract year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> and certain benefit categories with a <u>copay</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes, <u>Prescription drugs</u> -- \$150 per person does not apply to Tier 1 drugs. There are no other <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	Network: \$8,000 Individual / \$16,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.whyuhc.com/welcometouhc">www.whyuhc.com/welcometouhc</a> or call 1-800-444-6222 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay per visit, deductible does not apply	Not Covered	Virtual visits (Telehealth) - No Charge per visit by a Designated Virtual Network Provider.  No virtual coverage for out-of-Network.  If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Specialist visit	\$35 copay per visit, deductible does not apply	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/immunization	No Charge	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.
If you have a test	Diagnostic test (x-ray, blood work)	Office Lab: \$35 copay per visit, deductible does not apply Free Standing Lab: 50% coinsurance Hospital Lab: 50% coinsurance Free Standing X-ray: \$80 copay per service Hospital X-ray: \$80 copay per service	Not Covered	Designated Network Lab: No Charge
	Imaging (CT/PET scans, MRIs)	Free Standing: \$150 copay per service Hospital: \$150 copay per service	Not Covered	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 (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.whyuhc.com/welcometouhc">www.whyuhc.com/welcometouhc</a>	Tier 1	Retail: \$10 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$25 <u>copay</u> , <u>deductible</u> does not apply.	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply If you use a out of network-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. See the <u>website</u> listed for information on drugs covered by your <u>plan</u> . 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 <u>prescribed drugs</u> . Tier not applicable for this <u>plan</u> .
	Tier 2	Retail: \$40 <u>copay</u> Mail-Order: \$100 <u>copay</u>	Not Covered	
	Tier 3	Retail: \$80 <u>copay</u> Mail-Order: \$200 <u>copay</u>	Not Covered	
	Tier 4	Not Applicable	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Ctr: \$150 <u>copay</u> per service Hospital: \$150 <u>copay</u> per service	Not Covered	None
	Physician/surgeon fees	10% <u>coinsurance</u>	Not Covered	None
<b>If you need immediate medical attention</b>	Emergency room care	\$500 <u>copay</u> per visit, <u>deductible</u> does not apply	\$500 <u>copay</u> per visit, <u>deductible</u> does not apply	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	\$75 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	If you receive services in addition to <u>Urgent Care</u> visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	10% <u>coinsurance</u>	Not Covered	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 (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$35 copay per visit, deductible does not apply	Not Covered	Network partial hospitalization/intensive outpatient treatment/high intensity outpatient: 0% coinsurance Intensive Behavior Therapy (ABA): 0% coinsurance
	Inpatient services	10% coinsurance	Not Covered	None
<b>If you are pregnant</b>	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	10% coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	10% coinsurance	Not Covered	None
<b>If you need help recovering or have other special health needs</b>	Home health care	\$35 copay per visit, deductible does not apply	Not Covered	Limited to 40 visits per Calendar year.
	Rehabilitation services	\$35 copay per outpatient visit, deductible does not apply	Not Covered	Limits per condition per Calendar year: Physical, Speech and Occupational therapy combined limit 60 visits.
	Habilitation services	\$35 copay per outpatient visit, deductible does not apply	Not Covered	Limits per condition per Calendar year: Physical, Speech and Occupational therapy combined limit 60 visits.
	Skilled nursing care	10% coinsurance	Not Covered	None
	Durable medical equipment	10% coinsurance	Not Covered	Preauthorization required for DME over \$500 or there is no coverage
	Hospice services	10% coinsurance	Not Covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	\$15 copay per visit, deductible does not apply	Not Covered	Limited to 1 exam per 12 month period. Covered for individuals up to the age of 19.
	Children's glasses	50% coinsurance, deductible does not apply	Not Covered	One pair every 12 months. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Covered for individuals up to the age of 19.
	Children's dental check-up	0% coinsurance	Not Covered	Cleanings are covered 2 times per 12 months. Additional limitations may apply. Covered for individuals up to the age of 19.

**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.)**

- |                            |   |                        |
|----------------------------|---|------------------------|
| • Acupuncture              | • Cosmetic Surgery                                      | • Dental Care (Adult)  |
| • Long-Term Care           | • Non-emergency care when travelling outside - the U.S. | • Routine Foot Care    |
| • Routine Eye Care (Adult) |   | • Weight Loss Programs |

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

- |   |                                    |                |
|---|------------------------------------|----------------|
| • Bariatric Surgery                               | • Chiropractic (Manipulative) Care | • Hearing aids |
| • Infertility Treatment – Cycle limits may apply. | • Private duty nursing             |                |

**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, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or you may also contact us at 1-800-782-3740. 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 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: your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the New York Department of Financial Services at 1-800-342-3736 or [www.dfs.ny.gov/index.htm](http://www.dfs.ny.gov/index.htm).

**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 1-800-782-3740.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-782-3740.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-782-3740.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-782-3740 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-782-3740.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-782-3740.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-800-782-3740.

*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 \$1,750
- Specialist copayment \$35
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**This EXAMPLE event includes services like:**  
 Specialist office visits (*prenatal 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>	
Deductibles	\$1,750
Copayments	\$10
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,620</b>

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

- The plan's overall deductible \$1,750
- Specialist copayment \$35
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**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>	
Deductibles	\$200
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$600</b>

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

- The plan's overall deductible \$1,750
- Specialist copayment \$35
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**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:**

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$900</b>

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