

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

Coverage for: Employee/Family | Plan Type: EPO



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 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 1-800-444-6222 to request a copy.

Table with 3 columns: Important Questions, Answers, and Why This Matters. Rows include deductible amounts, preventive care coverage, out-of-pocket limits, network providers, and referral requirements.

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	\$40 <u>copay</u> per visit	Not Covered	Virtual visits (Telehealth) - 0% <u>coinsurance</u> 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 <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
	Specialist visit	\$75 <u>copay</u> per visit	Not Covered	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> 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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Office Lab: \$75 <u>copay</u> per visit Free Standing Lab: \$15 <u>copay</u> per service Hospital Lab: \$15 <u>copay</u> per service Free Standing X-ray: 50% <u>coinsurance</u> Hospital X-ray: 50% <u>coinsurance</u>	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing: 50% <u>coinsurance</u> Hospital: 50% <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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.whyuhc.com/welcometouhc	Tier 1	Retail: \$10 <u>copay</u> Mail-Order: \$25 <u>copay</u>	Not Covered	Provider means pharmacy for purposes of this section.
	Tier 2	Retail: \$40 <u>copay</u> Mail-Order: \$100 <u>copay</u>	Not Covered	Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply
	Tier 3	Retail: \$80 <u>copay</u> Mail-Order: \$200 <u>copay</u>	Not Covered	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 website 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 4	Not Applicable	Not Covered	Tier not applicable for this <u>plan</u> .
	If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Ctr: \$500 <u>copay</u> per service Hospital: \$500 <u>copay</u> per service	Not Covered
If you need immediate medical attention	Physician/surgeon fees	50% <u>coinsurance</u>	Not Covered	None
	Emergency room care	\$500 <u>copay</u> per visit	\$500 <u>copay</u> per visit*	*Network Deductible applies
	Emergency medical transportation	50% <u>coinsurance</u>	50% <u>coinsurance</u> *	*Network Deductible applies
	Urgent care	\$100 <u>copay</u> per visit	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.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	50% <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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$75 <u>copay</u> per visit	Not Covered	Network partial hospitalization/intensive outpatient treatment/high intensity outpatient: 0% <u>coinsurance</u> Intensive Behavior Therapy (ABA): 0% <u>coinsurance</u>
	Inpatient services	50% <u>coinsurance</u>	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply.
	Childbirth/delivery professional services	50% <u>coinsurance</u>	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	50% <u>coinsurance</u>	Not Covered	None
If you need help recovering or have other special health needs	Home health care	\$75 <u>copay</u> per visit	Not Covered	Limited to 40 visits per Calendar year.
	Rehabilitation services	\$75 <u>copay</u> per outpatient visit	Not Covered	Limits per condition per Calendar year: Physical, Speech and Occupational therapy combined limit 60 visits.
	Habilitation services	\$75 <u>copay</u> per outpatient visit	Not Covered	Limits per condition per Calendar year: Physical, Speech and Occupational therapy combined limit 60 visits.
	Skilled nursing care	50% <u>coinsurance</u>	Not Covered	None
	Durable medical equipment	50% <u>coinsurance</u>	Not Covered	Preauthorization required for DME over \$500 or there is no coverage
	Hospice services	50% <u>coinsurance</u>	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to 1 exam per 12 month period. Covered for individuals up to the age of 19.
	Children's glasses	50% <u>coinsurance</u>	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% <u>coinsurance</u>	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.)

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|----------------------------|---|------------------------|
| • 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.)

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| • 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 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 or the New York Department of Financial Services at 1-800-342-3736 or 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	\$6,500
■ Specialist copayment	\$75
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$6,500
Copayments	\$0
Coinsurance	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$8,060

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

■ The plan's overall deductible	\$6,500
■ Specialist copayment	\$75
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,700

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

■ The plan's overall deductible	\$6,500
■ Specialist copayment	\$75
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
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