UnitedHealthcare Oxford **NY G FRDM NG 25/40/1750/80 EPO 25**

**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.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: $1,750 Individual / $3,500 Family Per Policy year. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have 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 and certain benefit categories with a copay are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the 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?** | Yes, Prescription drugs -- $150 per person does not apply to Tier 1 drugs. There are no other deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | Network: $6,500 Individual / $13,000 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-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, and health care this plan doesn't cover. | 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 www.whyuhc.com/welcometouhc or call 1-800-444-6222 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 use an out-of-network provider for some 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 (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 | $25 copay per visit, deductible does not apply | Not Covered | Virtual visits (Telehealth) - No Charge per visit by a Designated Virtual Network Provider.<br>No virtual coverage for out-of-Network.<br>If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery. |
| | Specialist visit | $40 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) | Free Standing<br>Lab: 50% coinsurance<br>Hospital Lab: 50% coinsurance<br>Free Standing<br>X-ray: $80 copay per service<br>Hospital X-ray: $80 copay per service | Not Covered | Designated Network Lab: No Charge |
| | Imaging (CT/PET scans, MRIs) | Free Standing:<br>$150 copay per service<br>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) | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.whyuhc.com/welcometouhc | Tier 1 | Retail: $10 copay , deductible does not apply.<br>Mail-Order: $25 copay, deductible does not apply. | Not Covered | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 30-day supply<br>Mail-Order: Up to a 90-day supply<br>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.<br>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.<br>Certain drugs may have a preauthorization requirement or may result in a higher cost.<br>Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge.<br>See the website listed for information on drugs covered by your plan. Not all drugs are covered.<br>You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. |
| | Tier 2 | Retail: $40 copay<br>Mail-Order: $100 copay | Not Covered | |
| | Tier 3 | Retail: $80 copay<br>Mail-Order: $200 copay | Not Covered | |
| | Tier 4 | Not Applicable | Not Applicable | Tier not applicable for this plan. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Ambulatory Surgery Ctr: $150 copay per service<br>Hospital: $150 copay per service | Not Covered | None |
| | Physician/surgeon fees | 20% coinsurance | Not Covered | None |
| **If you need immediate medical attention** | Emergency room care | $500 copay per visit, deductible does not apply | $500 copay per visit, deductible does not apply | None |
| | Emergency medical transportation | No Charge | No Charge | None |
| | Urgent care | $75 copay per visit, deductible does not apply | Not Covered | If you receive services in addition to Urgent Care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery. |

| 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 have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not Covered | None |
| | Physician/surgeon fees | 20% coinsurance | Not Covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $40 copay per visit, deductible does not apply | Not Covered | Network partial hospitalization/intensive outpatient treatment/high intensity outpatient: 0% coinsurance<br>Intensive Behavior Therapy (ABA): 0% coinsurance |
| | Inpatient services | 20% coinsurance | Not Covered | None |
| **If you are pregnant** | 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 | 20% coinsurance | Not Covered | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery facility services | 20% coinsurance | Not Covered | None |
| **If you need help recovering or have other special health needs** | Home health care | $40 copay per visit, deductible does not apply | Not Covered | Limited to 40 visits per policy year. |
| | Rehabilitation services | $40 copay per outpatient visit, deductible does not apply | Not Covered | Limits per condition per policy year: Physical, Speech and Occupational therapy combined limit 60 visits. |
| | Habilitation services | $40 copay per outpatient visit, deductible does not apply | Not Covered | Limits per condition per policy year: Physical, Speech and Occupational therapy combined limit 60 visits. |
| | Skilled nursing care | 20% coinsurance | Not Covered | None |
| | Durable medical equipment | 20% coinsurance | Not Covered | Preauthorization required for DME over $500 or there is no coverage |
| | Hospice services | 20% coinsurance | Not Covered | None |
| **If your child needs dental or eye care** | Children's eye exam | $25 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<br>• Long-Term Care | • Cosmetic Surgery<br>• Non-emergency care when travelling outside - the U.S. | • Dental Care (Adult)<br>• Routine Foot Care<br>• 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<br>• Infertility Treatment – Cycle limits may apply. | • Chiropractic (Manipulative) Care<br>• Private duty nursing | • Hearing aids<br>• Routine Eye Care (Adult) |

**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, kwiijigo holne' 1-800-782-3740.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, 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, å'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** **$40**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,750 |
| Copayments | $10 |
| Coinsurance | $1,600 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,420** |

### 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** **$40**
- **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 | $200 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$600** |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,750**
- **Specialist copayment** **$40**
- **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 | $200 |
| Copayments | $700 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$900** |

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