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 888-904-4928. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-3.pdf or call 888-904-4928 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$1,000**/individual; **$2,000**/family Out-of-network: **$2,000**/individual; **$4,000**/family	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.	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 https://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 this plan?	In-network: **$6,000**/individual; **$12,000**/family Out-of-network: **$7,500**/individual; **$15,000**/family Prescription Drug: **$1,600** Individual/**$3,200** 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, expenses that are reimbursed at less than the plan coinsurance rate, penalties for failure to obtain pre-authorization for services 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.uhc.com or call 888-904-4928 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
		In-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	$30 copay/visit; deductible waived	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.	None.
	Specialist visit	$45 copay/visit; deductible waived		
	Preventive care/screening/ immunization	No charge.	No charge.	Age and frequency schedules may apply. 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)	No charge.	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.	For outpatient testing at a Hospital, the deductible and 20% coinsurance will apply.
	Imaging (CT/PET scans, MRIs)	$150 copay/service; deductible waived	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.	For outpatient testing at a Hospital, the deductible and 20% coinsurance will apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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 https://www.cap-rx.com/member-tools or 833-752-2779.	Generic drugs	$15 copay/prescription -Retail 30 day. $25 copay/prescription -Retail 90 day. $15 copay/prescription - Mail order 90 day.	Not covered.	Retail limit: 30-90-day supply. Mail order limit: 90-day supply.
	Preferred brand drugs	$45 copay/prescription -Retail 30 day. $75 copay/prescription -Retail 90 day. $60 copay/prescription - Mail order 90 day.	Not covered.	Retail limit: 30-90-day supply. Mail order limit: 90-day supply.
	Non-preferred brand drugs	$90 copay/prescription -Retail 30 day. $130 copay/prescription - Retail 90 day. $110 copay/prescription - Mail order 90 day.	Not covered.	Retail limit: 30-90-day supply. Mail order limit: 90-day supply.
	Specialty drugs	$125 copay/prescription - Retail 30 day.	Not covered.	Essential specialty medications are provided by CapitalRX through "Costco – Specialty Pharmacy," while non-essential specialty medications are not covered. For questions on essential specialty drugs please call 833-752-2779, and for assistance with non-essential specialty drugs contact Care Advocates at 844-922-7795.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	The deductible and then 10% coinsurance until the Maximum out-of-pocket expense is met.	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.	None.
	Physician/surgeon fees	The deductible and then 10% coinsurance until the Maximum out-of-pocket expense is met.	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$500 copay/visit; deductible waived.	$500 copay/visit; deductible waived.	Copay is waived if admitted into hospital.
	Emergency medical transportation	Ground - $100 copay/trip. Air - $100 copay/trip.	Ground - $100 copay/trip. Air - $100 copay/trip	For Emergency Transportation only.
	Urgent care	$75 copay/visit; deductible waived.	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	The deductible and then 10% coinsurance until the Maximum out-of-pocket expense is met.	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.	Prior authorization required for out-of-network care. Failure to receive prior authorization will result in a $300 penalty, call UMR at 866-494-4502.
	Physician/surgeon fees			None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	The deductible and then 10% coinsurance until the Maximum out-of-pocket expense is met.	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.	None.
	Inpatient services			Prior authorization required for out-of-network care. Failure to prior authorize will result in a $300 penalty, call Lower Hudson Valley-EAP 800-327-2799.
If you are pregnant	Office visits	$45 copay/visit; deductible waived	$45 copay/visit; deductible waived	Employee and Spouse; pre-natal care only for Dependent Children. Cost sharing does not apply for ACA-required preventive screenings. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	The deductible and then 10% coinsurance until the Maximum out-of-pocket expense is met.	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.	Employee and Spouse; pre-natal care only for Dependent Children. Precertification required for stays in excess of 48 hours for normal delivery (96 hours for cesarean delivery). Co-pay does not apply to newborn charges.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	$45 copay/visit; deductible waived.	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.	Limit: 120 visits/year combined in-network and out-of-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Rehabilitation services	$45 copay/visit; deductible waived.	20% coinsurance plus charges over allowed amount.	Physical and Speech therapy, and Chiropractic care, are covered 100% after a $5 copay for In-Network. Combined chiro/physical, occupational and speech therapy limit: 30 visits/year. After combined limit reached, solely up to 10 chiro visits may be allowed on a case-by-case basis.
	Habilitation services	Not Covered	Not Covered	You must pay 100% of these costs.
	Skilled nursing care	The deductible and then 10% coinsurance until the Maximum out-of-pocket expense is met.	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.	Limit: 90 days/year combined in-network and out-of-network.
	Durable medical equipment	$45 copay/item; deductible waived.	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.	New equipment allowed once every 2 consecutive years.
	Hospice services	$100 copay/admission; deductible waived.	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.	None.
If your child needs dental or eye care	Children's eye exam	$200 allowance		One exam every 12 months
	Children's glasses	Single Lenses: $200 max Bifocal Lenses: $240 max Trifocal Lenses: $250 max Frames: $325		One pair of prescription plastic or glass lenses once every 12 months; contact lenses permitted in lieu of glasses with $400 maximum allowance every 12 months.
	Children's dental check-up	No charge.	100% "Reasonable and Customary" amounts	Dental Exams/Cleanings/Fluoride: 3 per calendar year. No calendar year max for children under age 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.)

- Bariatric surgery
- Cosmetic surgery (except for accident or congenital disease/anomaly or following mastectomy)
- Long-term care
- Private-duty nursing
- Non-emergency care when traveling outside of USA
- Routine foot care
- Weight loss programs (except as required by ACA)

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

- Acupuncture (calendar year max 30 visits)
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)
- Dental 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: the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or 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 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 888-904-4928. You may also contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 888-904-4928.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-904-4928.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 888-904-4928.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-904-4928.

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** **$1,000**
- **Specialist copay** **$45**
- **Hospital coinsurance** **10%**
- **Drug copay** **$15/generic; $45/preferred brand**

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	$1,000
Copayments	$45
Coinsurance	$1,170
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,215**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copay** **$45**
- **Hospital coinsurance** **10%**
- **Drug copay** **$15/generic; $45/preferred brand**

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	$0
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$80**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copay** **$45**
- **Emergency room copay** **$500**
- **Drug copay** **$15/generic; $45/preferred brand**

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	$0
Copayments	$535
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$535**

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