



Gum Springs Union Plan



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.yourveoliabenefits.com or call 1-844-690-0918. 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 1-866-747-1020 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network</u> *: \$300.00 Individual / \$600.00 Family <u>Non-Network</u> *: \$600.00 Individual / \$1,200.00 Family per calendar year. * <u>Deductibles</u> cross-apply	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> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive Care</u> and primary care services with <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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the out-of-pocket limit for this plan?	Medical- For <u>network provider</u> *: \$1,500.00 Individual / \$3,000.00 Family For out-of-network <u>providers</u> *: \$3,000.00 Individual / \$6,000.00 Family per calendar year * <u>Out-of-pockets</u> cross-apply	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.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain <u>prior authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.myuhc.com or call 1-866-747-1020 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (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	\$20.00 copay /visit	35% coinsurance	Virtual Visit - In network \$8.00 copay per visit by a Designated Virtual Network Provider . No virtual visit coverage for out of network . If you receive services in addition to office visit, additional copays, deductibles , or co-ins may apply.
	Specialist visit	\$30.00 copay /visit	35% coinsurance	If you receive services in addition to office visit, additional copays, deductibles , or co-insurance may apply.
	Preventive care/screening/immunization	No charge	35% coinsurance	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)	15% coinsurance	35% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	35% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com</p>	Generic Drugs (Tier 1)	Retail (30 day supply): 10% coinsurance (max \$60) Mail Order (90 day supply): No cost	Member pays 100% of the costs and submits paper claim for reimbursement less the applicable coinsurance	<p>Your plan allows coverage for two 30-day fills of your long-term medications at any network pharmacy. After that, you will be required to fill your maintenance medications in 90-day supplies from Express-Scripts Home Delivery or by picking up a 90 day supply through a retail CVS Pharmacy.</p> <p>If you order a Non-Preferred Brand drug, you must meet the calendar-year deductible before the maximum coinsurance amount applies. The deductible (\$50 Individual/\$100 Family) is combined for retail pharmacy and mail delivery.</p> <p>Generic Drugs are free when you fill through the mail order program.</p> <p>Some drugs will be subject to Step Therapy where a generic alternative may be required to be tried prior to coverage of a brand; Prior Authorization for FDA approved uses; or Quantity Limitations based on manufacturer prescribing guidelines. Health Care Reform requires preventive items and services are covered without any cost-sharing if prescribed by a licensed practitioner.</p>
	Preferred brand drugs (Tier 2)	Retail (30 day supply): 20% coinsurance (max \$60) Mail Order (90 day supply): 20% coinsurance (max \$120)	Member pays 100% of the costs and submits paper claim for reimbursement less the applicable coinsurance	
	Non-preferred brand drugs (Tier 3)	Retail (30 day supply): 50% coinsurance (max \$60) Mail Order (90 day supply): 50% coinsurance (max \$120)	Member pays 100% of the costs and submits paper claim for reimbursement less the applicable coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Specialty drugs</u> (Tier 4)	Same as Retail for applicable formulary tier (Generic/Formulary/Non Formulary)	Not covered	Specialty drugs are limited to 30-day supplies and can only be filled through an Express-Scripts Specialty Pharmacy (Accredo). Your medication may be subject to utilization management including prior authorization to confirm diagnosis and adherence to nationally established clinical guidelines, step therapy wherein a therapeutic alternative may be required prior to coverage of the requested medication, and/or quantity limits to confirm appropriate dosing per FDA and/or nationally established clinical guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network.
	Physician/surgeon fees	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$75.00 <u>copay</u> /visit	\$75.00 <u>copay</u> /visit	None
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$20.00 <u>copay</u> /visit	35% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Physician/surgeon fees	15% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20.00 <u>copay</u> /visit	35% <u>coinsurance</u>	Prior Authorization required out-of-network for certain treatments, partial hospitalization/intensive outpatient treatment and Intensive Behavioral Therapy (ABA). Partial Hospitalization/Intensive Outpatient Treatment and Intensive Behavior Therapy (ABA) in-network 15% coinsurance after deductible and out of network 35% coinsurance after deductible. EAP Vendor Magellan 1-800-324-8914 EAP - 6 counseling sessions per Calendar Year
	Inpatient services	15% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for certain treatments for inpatient facility.
If you are pregnant	Office visits	\$20.00 <u>copay</u> /initial visit only	35% <u>coinsurance</u>	<u>Prior Authorization</u> required for out-of-network for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound)
	Childbirth/delivery professional services	15% <u>coinsurance</u>	35% <u>coinsurance</u>	
	Childbirth/delivery facility services	15% <u>coinsurance</u>	35% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Limited to 120 visits per calendar year for <u>Home Health Care</u> combined In and Out-of- <u>Network</u> . <u>Prior Authorization</u> required out-of- <u>network</u> for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN).
	<u>Rehabilitation services</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Physical, Occupational, Speech Therapy - 30 visits per calendar year each therapy combined In and Out of <u>Network</u> . Visit Limit does not apply to members with a behavioral diagnosis.
	<u>Habilitation services</u>	\$30.00 <u>copay</u> /visit	35% <u>coinsurance</u>	<u>Habilitation Services</u> are provided, and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> . 100 days per calendar year combined <u>network</u> and non- <u>network</u> .
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> for DME over \$1,000.
	<u>Hospice services</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> for <u>Home Health Care</u> before admission for an inpatient stay in a hospice facility.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Child routine vision exam is not covered.
	Children's glasses	Not covered	Not covered	Child glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Child dental check-up is not covered.

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.)

- | | | |
|--|---|--|
| <ul style="list-style-type: none">• Adult routine vision exam (i.e. refraction)• Cosmetic Surgery• Dental Care (Adult) | <ul style="list-style-type: none">• Infertility treatment• Long-term care• Private-duty nursing | <ul style="list-style-type: none">• Routine foot care• Weight loss programs |
|--|---|--|

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

- | | | |
|---|--|--|
| <ul style="list-style-type: none">• Acupuncture• Bariatric Surgery | <ul style="list-style-type: none">• Chiropractic care• Hearing aids | <ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S. |
|---|--|--|

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform><https://www.dol.gov/ebsa/healthreform><https://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 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: 1-866-747-1020 or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or <https://www.dol.gov/ebsa/healthreform>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? No

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 1-866-747-1020.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-747-1020.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-866-747-1020.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-866-747-1020 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-747-1020.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-747-1020.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-747-1020.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-747-1020.

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** \$300.00
- **Specialist copayment** \$30.00
- **Hospital (facility) coinsurance** 15%
- **Other coinsurance** 15%

This EXAMPLE event includes services like:

- Specialist office visits (*pre-natal 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>	
<u>Deductibles</u>	\$300.00
<u>Copayments</u>	\$0.00
<u>Coinsurance</u>	\$1,200.00
<i>What isn't covered</i>	
Limits or exclusions	\$70.00
The total Peg would pay is	\$1,570.00

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$300.00
- **Specialist copayment** \$30.00
- **Hospital (facility) coinsurance** 15%
- **Other coinsurance** 15%

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>	
<u>Deductibles</u>	\$100.00
<u>Copayments</u>	\$200.00
<u>Coinsurance</u>	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$4,300.00
The total Joe would pay is	\$4,600.00

Mia's Simple Fracture

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

- **The plan's overall deductible** \$300.00
- **Specialist copayment** \$30.00
- **Hospital (facility) coinsurance** 15%
- **Other coinsurance** 15%

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>	
<u>Deductibles</u>	\$300.00
<u>Copayments</u>	\$200.00
<u>Coinsurance</u>	\$200.00
<i>What isn't covered</i>	
Limits or exclusions	\$10.00
The total Mia would pay is	\$710.00