




## CDHP2 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.gateshealth.com](http://www.gateshealth.com) or call [www.myuhc.com](http://www.myuhc.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 1-866-787-6864 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<u>Network</u> *: \$3,000.00 Individual / \$6,000.00 Family <u>Non-Network</u> *: \$6,000.00 Individual / \$12,000.00 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive Care</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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	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.
<b>What is the out-of-pocket limit for this plan?</b>	For <u>network provider</u> *: \$6,000.00 Individual / \$12,000.00 Family For <u>out-of-network providers</u> *: \$12,000.00 Individual / \$24,000.00 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.
<b>What is not included in the out-of-pocket limit?</b>	<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 <b>network provider</b> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-787-6864 for a list of <b>network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No	You can see the <b>specialist</b> you choose without a <b>referral</b> .

 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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	20% <b>coinsurance</b>	50% <b>coinsurance</b>	Virtual visit - In- <b>network</b> 20% after <b>deductible</b> by a Designated Virtual <b>Network Provider</b> . If you receive services in addition to office visit, additional copays, <b>deductibles</b> , or co-ins may apply. No virtual visit coverage for Out-of- <b>network</b> .
	<b>Specialist</b> visit	20% <b>coinsurance</b>	50% <b>coinsurance</b>	If you receive services in addition to office visit, additional copays, <b>deductibles</b> , or co-ins may apply.
	<b>Preventive care/screening/immunization</b>	No charge	50% <b>coinsurance</b>	You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are <b>preventive</b> . Then check what your <b>plan</b> will pay for.
If you have a test	<b>Diagnostic test</b> (x-ray, blood work)	20% <b>coinsurance</b>	50% <b>coinsurance</b>	<b>Prior Authorization</b> required out-of- <b>network</b> for certain services.
	Imaging (CT/PET scans, MRIs)	20% <b>coinsurance</b>	50% <b>coinsurance</b>	<b>Prior Authorization</b> required out-of- <b>network</b> .

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)	
<b>If you need drugs to treat your illness or condition</b> <b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.optumrx.com">www.optumrx.com</a></b>	Generic Drugs (Tier 1)	Retail: N/A Mail Order: N/A	Retail: N/A Mail Order: N/A	None
	Preferred brand drugs (Tier 2)	Retail: N/A Mail Order: N/A	Retail: N/A Mail Order: N/A	None
	Non-preferred brand drugs (Tier 3)	Retail: N/A Mail Order: N/A	Retail: N/A Mail Order: N/A	None
	<u>Specialty drugs</u> (Tier 4)	Retail: N/A Mail Order: N/A	Retail: N/A Mail Order: N/A	None
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$0 Confinement <u>Deductible</u> 20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for certain services. EAP Amaze 5 sessions “per issue” per calendar year.
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for inpatient facility.
<b>If you are pregnant</b>	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

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)	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<p><u>Prior Authorization</u> required out-of-network for Inpatient stays that exceed normal 48 hours for natural delivery or 96 hours for cesarean.</p> <p><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.</p> <p>Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound).</p>
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Home Health Care</u> is limited to 120 visits per calendar year. <u>Prior Authorization</u> required out-of-network for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN).
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Physical, speech and occupational therapy is limited to 30 visits each per calendar year. Cardiac and Pulmonary Rehabilitation is unlimited.
	<u>Habilitation services</u>	Not covered	Not covered	<u>Habilitation services</u> are not covered.
	<u>Skilled nursing care</u>	\$0 Confinement <u>Deductible</u> 20% <u>coinsurance</u>	\$0 Confinement <u>Deductible</u> 50% <u>coinsurance</u>	Limited to 120 days per calendar year. <u>Prior Authorization</u> required out-of-network.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for DME over \$1,000.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network before admission for an inpatient stay in a hospice facility.

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 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Adult routine vision exam (i.e. refraction)</li> <li>• Bariatric Surgery</li> <li>• Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Dental Care (Adult)</li> <li>• <u>Habilitation services</u></li> <li>• Hearing aids</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> <li>• Routine foot care</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss programs</li> </ul>

**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>. 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: 1-866-787-6864 or visit [www.welcometouhc.com](http://www.welcometouhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? No**

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 1-866-787-6864.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-787-6864.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-787-6864.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-866-787-6864 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-787-6864.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-787-6864.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-787-6864.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-787-6864.

*—————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 \$3,000.00
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,000.00
<u>Copayments</u>	\$0.00
<u>Coinsurance</u>	\$1,900.00
<i>What isn't covered</i>	
Limits or exclusions	\$70.00
<b>The total Peg would pay is</b>	<b>\$4,970.00</b>

**Managing Joe's type 2 Diabetes**

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

- The plan's overall deductible \$3,000.00
- Specialist coinsurance 20%
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,100.00
<u>Copayments</u>	\$0.00
<u>Coinsurance</u>	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$4,300.00
<b>The total Joe would pay is</b>	<b>\$5,400.00</b>

**Mia's Simple Fracture**

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

- The plan's overall deductible \$3,000.00
- Specialist coinsurance 20%
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,800.00
<u>Copayments</u>	\$0.00
<u>Coinsurance</u>	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$10.00
<b>The total Mia would pay is</b>	<b>\$2,810.00</b>