




## PP1- Options PPO Retiree Pre- 65



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 1-866-787-6864. 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 <u>deductible</u>?</b>	<u>Network</u> : \$250.00 Individual / \$0.00 Family <u>Non-Network</u> : \$250.00 Individual / \$0.00 Family per calendar year.	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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	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.
<b>Are there other <u>deductibles</u> 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 <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Medical - This <u>plan</u> has no <u>out-of-pocket limit</u> .	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket</u> on your expenses.
<b>Will you pay less if you use a <u>network provider</u>?</b>	Not Applicable	This <u>plan</u> does not use a <u>provider network</u> . You can receive covered services from any <u>provider</u> .
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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	\$25.00 <u>copay</u> /visit	\$25.00 <u>copay</u> /visit	If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or co-insurance may apply
	<u>Specialist</u> visit	\$25.00 <u>copay</u> /visit	\$25.00 <u>copay</u> /visit	If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or co-insurance may apply
	<u>Preventive care/screening/immunization</u>	No charge	No charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> for certain services.
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	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
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Emergency room care</u>	\$65.00 <u>copay</u> /visit	\$65.00 <u>copay</u> /visit	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 immediate medical attention	<u>Emergency medical transportation</u>	\$25.00 <u>copay</u> /visit	\$25.00 <u>copay</u> /visit	None
	<u>Urgent care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	\$0 <u>Confinement Deductible</u> , 0% <u>coinsurance</u>	None
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25.00 <u>copay</u> /visit then 0% <u>coinsurance</u>	\$25.00 <u>copay</u> /visit then 0% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for certain treatments, partial <u>hospitalization</u> /intensive outpatient treatment.
	Inpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for inpatient facility.
If you are pregnant	Office visits	\$25.00 <u>copay</u> /initial visit only	\$25.00 <u>copay</u> /visit	<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	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Childbirth/delivery facility services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Habilitation services</u>	Not covered	Not covered	<u>Habilitation services</u> are not covered.
	<u>Skilled nursing care</u>	\$0 <u>Confinement Deductible</u> , 0% <u>coinsurance</u>	0% <u>coinsurance</u>	100 annual visit limit
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Hospice services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	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)	
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	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>• Acupuncture</li> <li>• Adult routine vision exam (i.e. refraction)</li> <li>• Bariatric Surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <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>• Routine foot care</li> <li>• Weight loss programs</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>• Private-duty nursing</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, kwijjigo 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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ <u>The plan's overall deductible</u>	\$250.00	■ <u>The plan's overall deductible</u>	\$250.00	■ <u>The plan's overall deductible</u>	\$250.00
■ <u>Specialist copayment</u>	\$25.00	■ <u>Specialist copayment</u>	\$25.00	■ <u>Specialist copayment</u>	\$25.00
■ <u>Hospital (facility) coinsurance</u>	0%	■ <u>Hospital (facility) coinsurance</u>	0%	■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	0%	■ <u>Other coinsurance</u>	0%	■ <u>Other coinsurance</u>	0%
<p>This EXAMPLE event includes services like:  <u>Specialist office visits (pre-natal care)</u>  <u>Childbirth/Delivery Professional Services</u>  <u>Childbirth/Delivery Facility Services</u>  <u>Diagnostic tests (ultrasounds and blood work)</u>  <u>Specialist visit (anesthesia)</u></p>		<p>This EXAMPLE event includes services like:  <u>Primary care physician office visits (including disease education)</u>  <u>Diagnostic tests (blood work)</u>  <u>Prescription drugs</u>  <u>Durable medical equipment (glucose meter)</u></p>		<p>This EXAMPLE event includes services like:  <u>Emergency room care (including medical supplies)</u>  <u>Diagnostic test (x-ray)</u>  <u>Durable medical equipment (crutches)</u>  <u>Rehabilitation services (physical therapy)</u></p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<u>Deductibles</u>		<u>Deductibles</u>		<u>Deductibles</u>	
<u>Copayments</u>		<u>Copayments</u>		<u>Copayments</u>	
<u>Coinsurance</u>		<u>Coinsurance</u>		<u>Coinsurance</u>	
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions		Limits or exclusions		Limits or exclusions	
<b>The total Peg would pay is</b>		<b>The total Joe would pay is</b>		<b>The total Mia would pay is</b>	

**Could not Calculate Coverage:  
Individual OOP Limit is required**