




Summary of Benefits and Coverage (SBC)

PLAN 5: Direct 90-10



2020 | 2021

 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, www.welcometouhc.com/oxford. 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 <http://www.dol.gov/ebsa/healthreform> or <http://www.cciio.cms.gov/> or call 1-800-444-6222 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network</u> : \$2,000 Individual / \$4,000 Family <u>Non-Network</u> : \$2,000 Individual / \$4,000 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> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and categories with a <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 annual <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>services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes, <u>Prescription drugs</u> -- \$100 per person does not apply to Tier 1 drugs There are no other <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	<u>Network</u> : \$5,000 Individual / \$10,000 Family <u>Non-Network</u> : \$10,000 Individual / \$20,000 Family	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 and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-800-444-6222 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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 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 <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	Virtual visits (Telehealth) - \$10 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> , <u>deductible</u> does not apply.
	<u>Specialist</u> visit	\$40 <u>copay</u> per visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge	30% <u>coinsurance</u>	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)	Lab: No Charge X-ray: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required non- <u>network</u> for certain services or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required non- <u>network</u> for certain services or benefit reduces to 50% of allowed.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com	Tier 1	Retail: \$25 <u>copay</u> , <u>deductible</u> does not apply Mail-Order: \$50 <u>copay</u> , <u>deductible</u> does not apply	Not Covered	<u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 90 day supply. <u>Copays</u> shown are for a 30 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement. Certain <u>preventive</u> medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered.
	Tier 2	Retail: \$50 <u>copay</u> Mail-Order: \$100 <u>copay</u>	Not Covered	
	Tier 3	Retail: \$75 <u>copay</u> Mail-Order: \$150 <u>copay</u>	Not Covered	
	Tier 4	Not Applicable	Not Applicable	Tier not applicable for this <u>plan</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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required <u>non-network</u> for certain services or benefit reduces to 50% of allowed.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required <u>non-network</u> for certain services or benefit reduces to 50% of allowed.
If you need immediate medical attention	Emergency room care	\$100 <u>copay</u> per visit, <u>deductible</u> does not apply	\$100 <u>copay</u> per visit, <u>deductible</u> does not apply	<u>Copay</u> waived if admitted to the hospital.
	Emergency medical transportation	10% <u>coinsurance</u> *	10% <u>coinsurance</u> *	* <u>Network deductible</u> applies
	Urgent care	\$40 <u>copay</u> per visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required <u>non-network</u> for certain services or benefit reduces to 50% of allowed.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required <u>non-network</u> for certain services or benefit reduces to 50% of allowed.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay</u> per visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Network</u> Partial hospitalization/intensive outpatient treatment: 10% <u>coinsurance</u> . <u>Preauthorization</u> required <u>non-network</u> for certain services or benefit reduces to 50% of allowed.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required <u>non-network</u> for certain services or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	30% <u>coinsurance</u>	<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.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Inpatient <u>preauthorization</u> may apply.

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 help recovering or have other special health needs	<u>Home health care</u>	\$40 <u>copay</u> per visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	Limited to 60 visits per calendar year. <u>Preauthorization</u> required non- <u>network</u> for certain services or benefit reduces to 50% of allowed.
	<u>Rehabilitation services</u>	\$40 <u>copay</u> per outpatient visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	Limits per calendar year: Physical, speech and occupational therapy combined limit 60 visits. <u>Preauthorization</u> required non- <u>network</u> for certain services or benefit reduces to 50% of allowed.
	<u>Habilitation services</u>	\$40 <u>copay</u> per outpatient visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	Limits per calendar year: Physical, speech and occupational therapy combined limit 60 visits. <u>Preauthorization</u> required non- <u>network</u> for certain services or benefit reduces to 50% of allowed.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 30 days per calendar year. <u>Preauthorization</u> required non- <u>network</u> for certain services or benefit reduces to 50% of allowed.
	<u>Durable medical equipment</u>	No Charge	30% <u>coinsurance</u>	<u>Preauthorization</u> required for DME over \$500 or there is no coverage.
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 180 days (combined inpatient and home hospice) per lifetime. <u>Preauthorization</u> required non- <u>network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exam.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

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.)

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| <ul style="list-style-type: none"> • Acupuncture • Children's glasses • Cosmetic surgery • Dental care (Adult/Child) | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when travelling outside - the U.S. | <ul style="list-style-type: none"> • Private duty nursing • Routine eye care (Adult/Child) • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none"> • Bariatric Surgery | <ul style="list-style-type: none"> • Chiropractic (Manipulative) care • Hearing Aids | <ul style="list-style-type: none"> • Infertility Treatment |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|

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: www.state.nj.us/dobi/index.html, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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 Jersey Department of Banking and Insurance at 1-800-446-7467 or www.state.nj.us/dobi/index.html.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-633-2446.

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)	
■ The <u>plan's</u> overall <u>deductible</u>	\$2,000	■ The <u>plan's</u> overall <u>deductible</u>	\$2,000	■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> copay	\$40	■ <u>Specialist</u> copay	\$40	■ <u>Specialist</u> copay	\$40
■ Hospital (facility) <u>coinsurance</u>	10%	■ Hospital (facility) <u>coinsurance</u>	10%	■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%	■ Other <u>coinsurance</u>	10%	■ Other <u>coinsurance</u>	10%
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,000	<u>Deductibles</u>	\$300	<u>Deductibles</u>	\$750
<u>Copayments</u>	\$40	<u>Copayments</u>	\$1,900	<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$800	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$30	Limits or exclusions	\$0
The total Peg would pay is	\$2,900	The total Joe would pay is	\$2,230	The total Mia would pay is	\$1,050