Employee Benefits Enrollment Guide

Plan Year: July 1, 2026-June 30, 2027




PAYCHEX

Payroll | Benefits | HR | Insurance

The Power of Simplicity

2026 – 2027 Benefits Enrollment Guide

Kulanu Academy recognizes the importance of being able to provide our employees and their families with quality benefits as part of their overall compensation package. Therefore, Kulanu Academy . has developed a comprehensive benefits package that delivers quality and value while satisfying the diverse needs of our workforce. This summary highlights the benefit options offered by Kulanu Academy .

Open Enrollment

For newly hired employees or for those who become newly eligible during the plan year, you must enroll n o later than 30 days after your eligibility date or the date of your change in eligibility status. All other eligi ble employees must enroll during open enrollment, which this year is from May 26, 2025-June 15,2025.

Eligibility

If you are an employee working at least 30 hours a week, you are eligible for the benefits outlined in this guide. Eligible employees may elect to cover their spouse or children to age 26. Benefits are effective on the first of the month following the date of hire.

Qualifying Event

Employee contributions for medical benefits are payroll deducted on a pre-tax basis under IRC Section 125. Outside of open enrollment you are not permitted to make changes to your benefit elections unless you experience a qualifying event defined as: marriage, divorce or legal separation, birth or adoption of a child, a change in your or your spouse's employment or insurance status, a dependent ceasing to meet eligibility requirements, or a change in residence that affects coverage. If you experience a qualifying event, HR must notify the insurance company within 30 days of the qualifying event or you will not be able to make changes to your current election until the next open enrollment period. Please contact HR as soon as possible upon a qualifying event.

Please Note: This is a brief summary, actual policy provisions govern all benefits and costs.

2026 – 2027 Additional Employee Benefits

BalanceCare®

As part of your benefits package, you are eligible to take advantage of Balance*Care* – a confidential and complimentary health advocacy service designed to help you understand and maximize your health care benefits. Available 24/7, Balance*Care* will connect you to a health care professional ready to assist you in managing and resolving a variety of health care issues including: claims assistance, ordering ID cards, referrals, care coordination, specialty care, eldercare, Medicare, transportation, clinical trials, home health care services, hospital planning, assisted living and finances, and rehabilitation services. Access to Balance*Care* is easy, with two convenient options: call 877-598-8617 toll free or e-mail balancecare@eniweb.com.

Paychex Flex

Kulanu Academy employees have access to Paychex Flex. Members can log into PaychexFlex.com or download the Flex Mobile Application to view current elections, plan summaries, and additional plan documents.

Please Note: This is a brief summary, actual policy provisions govern all benefits and costs.

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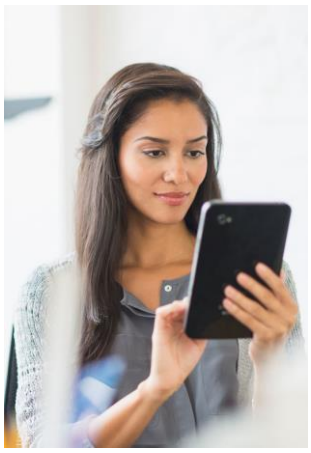
Enrolling Online with Paychex Flex



Follow these easy steps to elect your benefits for the next plan year:

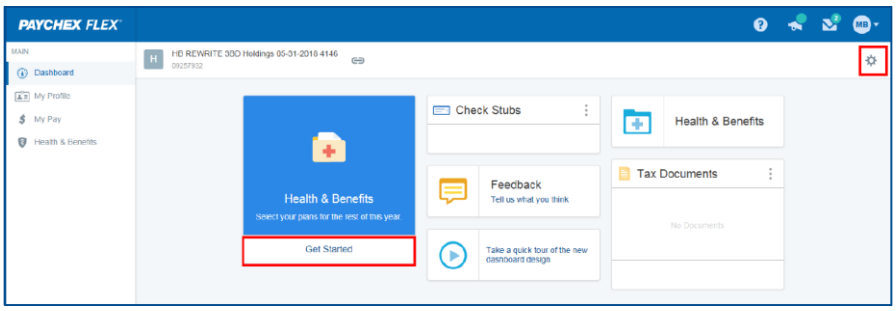
1. Create a Paychex Flex Account and Download the Paychex Flex Mobile Application.

2. Log into Paychex Flex from your Computer, Tablet or Smart Phone.

3. Access Health & Benefits From your Dashboard.

4. Choose Benefits!

Below you will find a tutorial if you have any further questions:
http://training.paychex.com/pia_health_benefits/employee/electing_benefits.html



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Rates are per paycheck SEMI-MONTHLY

7/1/26-6/30/27

Oxford Gold Freedom PPO				
	Tier 1	Tier 2	Tier 3	Tier 4
Employee	290.00	325.00	387.00	515.00
Employee	563.00	683.00	795.00	975.00
Employee	390.00	445.00	510.00	820.00
Family	795.00	820.00	847.00	1,372.00

Oxford Silver Liberty EPO				
	Tier 1	Tier 2	Tier 3	Tier 4
Employee	162.00	205.00	251.00	382.00
Employee	318.00	400.00	520.00	732.00
Employee	266.00	272.00	280.00	622.00
Family	435.00	480.00	457.00	995.00

Oxford Bronze Liberty EPO HSA				
	Tier 1	Tier 2	Tier 3	Tier 4
Employee	176.00	162.00	142.00	125.00
Employee	405.00	405.00	405.00	405.00
Employee	345.00	345.00	345.00	345.00
Family	726.00	726.00	726.00	726.00

New York Health Benefits Waiver of Coverage

UnitedHealthcare® Oxford

Mailing Address: Oxford Enrollment Dept. ■ P.O. Box 29142 ■ Hot Springs, AR 71903 ■ 1-800-444-6222 ■ www.oxfordhealth.com

Group Name: Kulanu Academy

Group Policy Number (if known): _____

Employee Name: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Employment: _____

Date of Birth: _____

I am employed by and working at least 20 hours per week for the group shown above. I was given the opportunity to enroll in the Oxford* group health benefits plan(s) offered by my employer and I refuse coverage.

Reason for Refusal (please check all appropriate boxes)

☐ I have other coverage from:

- ☐ My spouse's employer
- ☐ Medicare
- ☐ Medicaid
- ☐ Veteran's Administration
- ☐ Union health plan
- ☐ Parental Waiver
- ☐ Another carrier's group health plan sponsored by this employer
- ☐ Another source of coverage (please specify): _____

REQUIRED INFORMATION: _____
Name of carrier Policy Number

☐ Other reason (please explain): _____

I certify that all information provided in this form is true and complete. By refusing group health benefits, I acknowledge that I and/or my dependent(s) may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Signature of Employee Date

Signature of Benefits Administrator Date

* Oxford insurance products are underwritten by Oxford Health Insurance, Inc.

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.whyuhc.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 or call 1-800-444-6222 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $1,500 Individual / $3,000 Family Out-of-Network: $4,000 Individual / $8,000 Family Per Policy year.	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. Preventive care and certain benefit categories with a copay are covered before you meet your deductible.	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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes, Prescription drugs -- $150 per person does not apply to Tier 1 drugs. There are no other deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: $7,250 Individual / $14,500 Family Out-of-Network: $10,500 Individual / $21,000 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, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	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.whyuhc.com/welcometouhc or call 1-800-444-6222 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
		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 copay per visit, deductible does not apply	40% coinsurance	Virtual visits (Telehealth) - No Charge per visit by a Designated Virtual Network Provider. No virtual coverage for out-of-Network. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Specialist visit	$40 copay per visit, deductible does not apply	40% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	40% 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. *Certain services are covered when using an Out-of-Network provider.
If you have a test	Diagnostic test (x-ray, blood work)	Office Lab: $40 copay per visit, deductible does not apply Free Standing Lab: 50% coinsurance Hospital Lab: 50% coinsurance Free Standing X-ray: $25 copay per service Hospital X-ray: $25 copay per service	Lab: Not Covered X-ray: 40% coinsurance	Designated Network Lab: No Charge Preauthorization required for certain services for out-of-network or benefit reduces to the lesser of 50% or $500.
	Imaging (CT/PET scans, MRIs)	Free Standing: $100 copay per service Hospital: $100 copay per service	40% coinsurance	Preauthorization required for certain services for out-of-network or benefit reduces to the lesser of 50% or $500.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.whyuhc.com/welcometouhc	Tier 1	Retail: $10 copay , deductible does not apply. Mail-Order: $25 copay, deductible does not apply.	Retail: $10 copay , deductible does not apply. Mail-Order: $25 copay, deductible does not apply.	Provider means pharmacy for purposes of this section. Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply If you use a out of network-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2	Retail: $40 copay Mail-Order: $100 copay	Retail: $40 copay Mail-Order: $100 copay	
	Tier 3	Retail: $80 copay Mail-Order: $200 copay	Retail: $80 copay Mail-Order: $200 copay	
	Tier 4	Not Applicable	Not Covered	Tier not applicable for this plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Ctr: $150 copay per service Hospital: $150 copay per service	40% coinsurance	Preauthorization required for certain services for out-of-network or benefit reduces to the lesser of 50% or $500.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization required for certain services for out-of-network or benefit reduces to the lesser of 50% or $500.
If you need immediate medical attention	Emergency room care	$500 copay per visit, deductible does not apply	$500 copay per visit, deductible does not apply	None
	Emergency medical transportation	20% coinsurance	20% coinsurance *	*Network Deductible applies
	Urgent care	$75 copay per visit, deductible does not apply	40% coinsurance	If you receive services in addition to Urgent Care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.

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 a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required for certain services for out-of-network or benefit reduces to the lesser of 50% or $500.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization required for certain services for out-of-network or benefit reduces to the lesser of 50% or $500.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay per visit, deductible does not apply	40% coinsurance	Network partial hospitalization/intensive outpatient treatment/high intensity outpatient: 0% coinsurance Preauthorization required for certain services for out-of-network or benefit reduces to the lesser of 50% or $500. Intensive Behavior Therapy (ABA): 0% coinsurance
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required for certain services for out-of-network or benefit reduces to the lesser of 50% or $500.
If you are pregnant	Office visits	No Charge	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Inpatient preauthorization may apply out-of-network or benefit reduces to the lesser of 50% or $500.
If you need help recovering or have other special health needs	Home health care	$40 copay per visit, deductible does not apply	40% coinsurance	Limited to 40 visits per policy year. Preauthorization required for certain services for out-of-network or benefit reduces to the lesser of 50% or $500.
	Rehabilitation services	$40 copay per outpatient visit, deductible does not apply	40% coinsurance	Limits per condition per policy year: Physical, Speech and Occupational therapy combined limit 60 visits. Preauthorization required for certain services for out-of-network or benefit reduces to the lesser of 50% or $500.

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)	
	Habilitation services	$40 copay per outpatient visit, deductible does not apply	40% coinsurance	Limits per condition per policy year: Physical, Speech and Occupational therapy combined limit 60 visits. Preauthorization required for certain services for out-of-network or benefit reduces to the lesser of 50% or $500.
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization required for certain services for out-of-network or benefit reduces to the lesser of 50% or $500.
	Durable medical equipment	20% coinsurance	Not Covered	Preauthorization required for DME over $500 or there is no coverage
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to the lesser 50% or $500.
If your child needs dental or eye care	Children's eye exam	$25 copay per visit, deductible does not apply	50% coinsurance	Limited to 1 exam per 12 month period. Covered for individuals up to the age of 19.
	Children's glasses	50% coinsurance, deductible does not apply	50% coinsurance	One pair every 12 months. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Covered for individuals up to the age of 19.
	Children's dental check-up	0% coinsurance	50% coinsurance	Cleanings are covered 2 times per 12 months. Additional limitations may apply. Covered for individuals up to the age of 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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-emergency care when travelling outside - the U.S.
- Routine Foot Care
- Routine Eye Care (Adult)
- Weight Loss Programs

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

- Bariatric Surgery
- Chiropractic (Manipulative) Care
- Hearing aids
- Infertility Treatment – Cycle limits may apply.
- Private duty nursing

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or you may also contact us at 1-800-782-3740. 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: your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the New York Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov/index.htm. .

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 1-800-782-3740.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-782-3740.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-782-3740.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-782-3740 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-782-3740.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-782-3740.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-782-3740.

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	**$1,500**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$1,500
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,270**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$1,500**
Specialist copayment	**$40**
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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$600**

Mia's Simple Fracture

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

The plan's overall deductible	**$1,500**
Specialist copayment	**$40**
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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

PPO plan details, all in one place

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	PPO
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities – but staying in the network can help lower your costs.	☑
Primary care physician (PCP) required With this plan, you need to select a PCP – the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☑
Freestanding centers You may pay less when you use certain freestanding centers – health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☑
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free.Use it to save and pay for qualified medical expenses.	☐

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how PPO works

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$1,500	$4,000
Family	$3,000	$8,000
Ped Dental Annual Deductible - Family	Included in your medical deductible	Included in your medical deductible
Ped Dental Annual Deductible - Individual	Included in your medical deductible	Included in your medical deductible

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

**After the Annual Medical Deductible has been met.*

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit		
Individual	$7,250	$10,500
Family	$14,500	$21,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services		
	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care Services *Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, coinsurance or deductible.* *Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.* *Out-of-network benefits are limited to mammograms, screening and diagnostic imaging for the detection of breast cancer, bone density screenings, routine gynecological services/well woman exams, prostate cancer screening, sterilization procedures for women, and well child visits and immunizations.*		No copay	40%*
Office Services - Sickness & Injury			
Primary Care Physician *Additional copays, deductible, or coinsurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*		$25 copay	40%*
Specialist *Additional copays, deductible, or coinsurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*		$40 copay	40%*
Telemedicine Program (Virtual Visits) *Network Benefits are available only when services are delivered through a Designated Virtual Network Provider for 24/7 Virtual Visit services only. You can find a 24/7 Virtual Visit Provider by contacting us at myuhc.com® or the telephone number on your ID card.*		No copay	Not covered
Urgent Care Center Services		$75 copay	40%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services		
	Designated Network	Network	Out-of-Network
Emergency Care			
Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services and Emergency Transportation including Air Ambulance)			
Air Ambulance		20%*	20%*
Ground Ambulance		20%*	20%*
Emergency Department *There is no cost for health care forensic examinations performed under Public Health Law §2805-i.*		$500 copay	$500 copay
Non-Emergency Ambulance (Ground and Air Ambulance)[1]			
Air Ambulance		20%*	20%*
Ground Ambulance		20%*	40%*
Inpatient Care			
Inpatient Habilitative Services (Physical, Speech & Occupational Therapy)[1] *Limited to 60 combined visits of physical therapy, occupational therapy and speech therapy per year.* *Limits do not apply to Inpatient Habilitation Services for a mental health condition or substance use disorder.*		20%*	40%*
Inpatient Hospital for a Continuous Confinement[1]		20%*	40%*
Inpatient Medical Visits[1]		20%*	40%*
Physician Fees for Surgical and Medical Services - Inpatient[1]		20%*	40%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1] *Limited to 60 days per year in an Inpatient Rehabilitation Facility.* *Limits do not apply to Inpatient Rehabilitation Services for a mental health condition or substance use disorder.* *The limit for Inpatient Rehabilitation Services applies to any combination of physical therapy, occupational therapy, and speech therapy.*		20%*	40%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services		
	Designated Network	Network	Out-of-Network
Outpatient Care			
Chiropractic Services		$40 copay	40%*
Habilitative Services - Outpatient[1] *Limited to 60 combined visits of physical therapy, occupational therapy and speech therapy per year.* *Limits do not apply to Habilitation Services for a mental health condition or substance use disorder.*		$40 copay	40%*
Home Health Care[1] *Limited to 40 visits per year.* *Home infusion therapy is not covered out-of-network.* *Limits do not apply to Home Health Care for a mental health condition or substance use disorder.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. Home infusion counts toward home health care visit limits.*		$40 copay	40%*
Lab, X-Ray and Diagnostic - Outpatient - Laboratory Procedures			
Performed as Outpatient Hospital Services	No copay	50%*	Not covered
Performed in a Freestanding Radiology Facility	No copay	50%*	Not covered
Performed in a PCP Office	No copay	$25 copay	Not covered
Performed in a Specialist Office	No copay	$40 copay	Not covered
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]			
Performed as Outpatient Hospital Services		$25 copay*	40%*
Performed in a Freestanding Radiology Facility		$25 copay*	40%*
Performed in a PCP Office		$25 copay	40%*
Performed in a Specialist Office		$40 copay	40%*
Major Diagnostic and Imaging - Outpatient Advanced Imaging Services and Therapeutic Radiology Services[1]			
Performed as Outpatient Hospital Services		$100 copay*	40%*
Performed in a Freestanding Radiology Facility		$100 copay*	40%*
Performed in a Specialist Office		$40 copay	40%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services		
	Designated Network	Network	Out-of-Network
Physician Fees for Surgical and Medical Services - Outpatient[1]			
For services provided at an ambulatory surgical center or in a physician's office		20%*	40%*
For services provided at an outpatient hospital-based surgical center		20%*	40%*
Rehabilitation Services - Outpatient Therapy[1] *Limited to 60 combined visits of physical therapy, occupational therapy and speech therapy per year.* *Limits do not apply to Rehabilitation Services for a mental health condition or substance use disorder.*		$40 copay	40%*
Surgery - Outpatient[1]			
For services provided at an ambulatory surgical center or in a physician's office		$150 copay*	40%*
For services provided at an outpatient hospital-based surgical center		$150 copay*	40%*
Therapeutic Treatments - Outpatient[1]			
Performed as Outpatient Hospital Services		$150 copay*	40%*
Performed in a Freestanding Radiology Facility		$40 copay	40%*
Performed in a PCP Office		$25 copay	40%*
Performed in a Specialist Office *Out of Network: Limited to 10 visits per year for dialysis.* *Dialysis is not covered out-of-network, except for up to 10 visits per calendar year from a non-network provider to be paid at the network level when approved in advance.*		$40 copay	40%*
Supplies and Services			
Diabetic Education		$25 copay	40%*
Diabetic Equipment and Supplies, Diabetic Insulin, Diabetic Oral Anti-Diabetic Agents and Injectible Anti-Diabetic Agents[1] *There is no cost in-network for insulin.*		$25 copay	40%*
Durable Medical Equipment and Braces		20%*	Not covered

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services		
	Designated Network	Network	Out-of-Network
External Hearing Aids *Limited to a single purchase per hearing impaired ear every 3 years.* *Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*		20%*	40%*
Prescription Drugs Administered in Office or Outpatient Facilities			
Performed in Outpatient Facilities		20%*	40%*
Performed in a PCP Office		$25 copay	40%*
Performed in a Specialist Office		$40 copay	40%*
This includes medications given at a doctor's office, or in a covered person's home.			
Prosthetic Devices[1]			
External		20%*	40%*
Internal		20%*	40%*
Limited to 1 prosthetic device per limb per lifetime. *Limit applies to External Prosthetic Devices only.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*			
Pregnancy			
Maternity and Newborn Care[1]			
Other Maternity Services and Newborn Care	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Outpatient Donor Breast Milk		20%*	40%*
One Home Care visit is covered at no cost-sharing if mother is discharged from Hospital early. *There is no cost for network prenatal and postnatal care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.*			
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient Hospital or Residential Facility[1]		20%*	40%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services		
	Designated Network	Network	Out-of-Network
Intensive Behavioral Therapy (e.g. ABA Treatment for Autism Spectrum Disorder)[1]		No copay*	
Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation and Medication Assisted Treatment[1]		No copay*	40%*
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs[1] *Includes Mental Health Outpatient Services provided in a Facility licensed, certified, or otherwise authorized by OMH.* *There is no cost for Network Opioid Treatment Programs.*		No copay*	40%*
Outpatient Office Visit *There is no cost for Network Opioid Treatment Programs.*		$40 copay	40%*
Other Services			
Abortion Services		No copay	40%*
Assistive Communication Devices for Autism Spectrum Disorder[1]		$25 copay	40%*
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.		
Hospice Care[1]			
Inpatient		20%*	40%*
Outpatient		$40 copay	40%*
Infertility Services[1]	The amount you pay is based on where the covered health care service is provided.		
Medical Supplies[1]		20%*	40%*
Obesity - Weight Loss Surgery[1]		20%*	40%*
Oral Surgery[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.		
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.		
Retail Health Care Clinic		$25 copay	40%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services		
	Designated Network	Network	Out-of-Network
Second and third Opinions *If you obtain a second opinion for a diagnosis of cancer from an out-of-Network provider, it will be covered at the Network Benefit level.* *Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist.* *There is no charge to you for second or third opinions requested by us.*		$40 copay	40%*
Transplantation Services[1] *For Network Benefits, transplantation services must be received from a Designated Provider.*		20%*	40%*
Wigs[1] *Limited to one wig per lifetime.*		20%*	40%*
Pediatric Services - Dental			
All Pediatric Dental - Benefits covered up to age 19 *Additional limits may apply. Refer to your plan documents for more information.*			
Basic Dental Services		20%*	50%*
Diagnostic Services *Limited to 1 time every 36 months for Panoramic x-rays.* *Limited to 2 evaluations (checkup exams) every 12 months.* *Limited to 2 series of films every 12 months of Bitewing x-rays.*		No copay*	50%*
Major Restorative Services		50%*	50%*
Medically Necessary Orthodontics[1] *All orthodontic treatment must be prior authorized.*		50%*	50%*
Preventive Services *Limited to 2 dental prophylaxis cleanings and fluoride treatments every 12 months.*		No copay*	50%*
Pediatric Services - Vision			
All Pediatric Vision - Benefits Covered up to age 19			

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services		
	Designated Network	Network	Out-of-Network
Contact Lenses/Necessary Contact Lenses *Limited to 1 fitting and evaluation every 12 months.* *Limited to a 12 month supply.* *We will pay benefits for only one vision care service. You may choose either eyeglasses (eyeglass lenses and/or eyeglass frames) or contact lenses.*		50%	50%*
Eyeglass Frames			
Eyeglass frames with a retail cost below $130.		50%	50%*
Eyeglass frames with a retail cost between $130-$160.		50%	50%*
Eyeglass frames with a retail cost between $160-$200.		50%	50%*
Eyeglass frames with a retail cost between $200-$250.		50%	50%*
Eyeglass frames with a retail cost greater than $250. *Limited to once every 12 months.*		50%	50%*
Eyeglass Lenses *Limited to once every 12 months.*		50%	50%*
Lens Extras *Limited to once every 12 months.* *Coverage includes polycarbonate lenses and standard scratch-resistant coating.*		No copay	No copay*
Routine Vision Exam *Limited to once every 12 months.*		$25 copay	50%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	Broad Rx Network
Prescription Drug List	Advantage
	In Network
Annual Pharmacy Deductible	
Individual	$150
Family	See Individual Deductible

**After the Annual Pharmacy Deductible has been met.*

Annual Pharmacy Deductible - Network and Out-of-Network

The Pharmacy Deductible is the amount you pay for pharmacy expenses per year before you begin to receive Pharmacy Benefits.

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail and Specialty Pharmacy Network	Out-of-Network Retail Pharmacy	Mail Order Pharmacy**
Tier 1 $	$10	$10	$25
Tier 2 $$	$40*	$40*	$100*
Tier 3 $$$	$80*	$80*	$200*

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.
Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.
If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

Here's an example of how the plan's costs come into play

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you – this is your **coinsurance.***

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year – copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, $15) –or **copay** – for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

*Your coinsurance may vary by service. This example is for illustrative purposes only.

Digital tools to keep you connected

Once you're a member, you can access your personalized digital tools – the **UnitedHealthcare® app** and **myuhc.com®** – these tools give you quick access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Access your health plan ID card and add your plan details to your smartphone's digital wallet
- Learn about covered preventive care
- Quickly compare cost estimates before you get care, which may help you save money

Get connected

Scan this code to download the UnitedHealthcare app or visit myuhc.com

Other important information about your benefits

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at an In-Network Retail Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The In- Network Retail Pharmacy Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from an In-Network Mail Order Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Retail Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) or pharmaceutical product(s) for which Benefits are provided as described under the Certificate first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

Certain Preventative Care Medications may be covered at zero costshare. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by an In-Network Mail Order Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how In-Network Mail Order Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through an In-Network Mail Order Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

• Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
• Certain compounded drugs.
• Diagnostic kits and products, including associated services.
• Drugs available over-the-counter, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this Certificate.
• Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
• Experimental or Investigational or Unproven Services and medications for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, you are entitled to an Appeal as described in the Utilization Review and External Appeal sections of the Certificate.
• General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
• Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
• Prescription Drug Products used for cosmetic or convenience purposes.
• Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
• Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill, except for assistive communication devices.
• We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.
• We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

UnitedHealthcare does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us such as letters in others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (**Vietnamese**), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (**Tagalog**), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русский (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة العضوية الخاصة بك.

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (**French**), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (**Polish**), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (**Portuguese**), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (**Italian**), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (**German**) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (**Hmong**), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά **(Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

PAKDAAR: Nu saritaem ti Ilocano (**Ilocano**), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (**Somali**), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

ગુજરાતી **(Gujarati)**: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપ્ય છે. મહેરબાની કરી તમારા આઇડી કાડડની સૂચિપર આપેલો સેભ્યે માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

United Healthcare®

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.whyuhc.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 or call 1-800-444-6222 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $3,250 Individual / $6,500 Family Per Policy year.	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. Preventive care and certain benefit categories with a copay are covered before you meet your deductible.	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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes, Prescription drugs -- $200 per person does not apply to Tier 1 drugs. There are no other deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: $9,200 Individual / $18,400 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, 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.whyuhc.com/welcometouhc or call 1-800-444-6222 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
		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	$40 copay per visit, deductible does not apply	Not Covered	Virtual visits (Telehealth) - No Charge per visit by a Designated Virtual Network Provider. No virtual coverage for out-of-Network. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Specialist visit	$80 copay per visit, deductible does not apply	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	Not Covered	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)	Office Lab: $80 copay per visit, deductible does not apply Free Standing Lab: 50% coinsurance Hospital Lab: 50% coinsurance Free Standing X-ray: 40% coinsurance Hospital X-ray: 40% coinsurance	Not Covered	Designated Network Lab: No Charge
	Imaging (CT/PET scans, MRIs)	Free Standing: 40% coinsurance Hospital: 40% coinsurance	Not Covered	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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.whyuhc.com/welcometouhc	Tier 1	Retail: $10 copay , deductible does not apply. Mail-Order: $25 copay, deductible does not apply.	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply If you use a out of network-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2	Retail: $50 copay Mail-Order: $125 copay	Not Covered	
	Tier 3	Retail: $90 copay Mail-Order: $225 copay	Not Covered	
	Tier 4	Not Applicable	Not Covered	Tier not applicable for this plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Ctr: 40% coinsurance Hospital: 40% coinsurance	Not Covered	None
	Physician/surgeon fees	40% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance *	*Network Deductible applies
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$100 copay per visit, deductible does not apply	Not Covered	If you receive services in addition to Urgent Care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not Covered	None
	Physician/surgeon fees	40% coinsurance	Not Covered	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 mental health, behavioral health, or substance abuse services	Outpatient services	$80 copay per visit, deductible does not apply	Not Covered	Network partial hospitalization/intensive outpatient treatment/high intensity outpatient: 0% coinsurance Intensive Behavior Therapy (ABA): 0% coinsurance
	Inpatient services	40% coinsurance	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	40% coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	40% coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	$80 copay per visit, deductible does not apply	Not Covered	Limited to 40 visits per policy year.
	Rehabilitation services	$80 copay per outpatient visit, deductible does not apply	Not Covered	Limits per condition per policy year: Physical, Speech and Occupational therapy combined limit 60 visits.
	Habilitation services	$80 copay per outpatient visit, deductible does not apply	Not Covered	Limits per condition per policy year: Physical, Speech and Occupational therapy combined limit 60 visits.
	Skilled nursing care	40% coinsurance	Not Covered	None
	Durable medical equipment	40% coinsurance	Not Covered	Preauthorization required for DME over $500 or there is no coverage
	Hospice services	40% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	$30 copay per visit, deductible does not apply	Not Covered	Limited to 1 exam per 12 month period. Covered for individuals up to the age of 19.
	Children's glasses	50% coinsurance, deductible does not apply	Not Covered	One pair every 12 months. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Covered for individuals up to the age of 19.
	Children's dental check-up	0% coinsurance	Not Covered	Cleanings are covered 2 times per 12 months. Additional limitations may apply. Covered for individuals up to the age of 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.)		
• Acupuncture • Long-Term Care • Routine Eye Care (Adult)	• Cosmetic Surgery • Non-emergency care when travelling outside - the U.S.	• Dental Care (Adult) • 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.)		
• Bariatric Surgery • Infertility Treatment – Cycle limits may apply.	• Chiropractic (Manipulative) Care • Private duty nursing	• Hearing aids

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or you may also contact us at 1-800-782-3740. 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: your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the New York Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov/index.htm. .

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 1-800-782-3740.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-782-3740.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-782-3740.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-782-3740 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-782-3740.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-782-3740.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-782-3740.

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	**$3,250**
Specialist copayment	**$80**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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	$3,250
Copayments	$10
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,020**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$3,250**
Specialist copayment	**$80**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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	$200
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$800**

Mia's Simple Fracture

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

The plan's overall deductible	**$3,250**
Specialist copayment	**$80**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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	$1,200
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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

EPO plan details, all in one place

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	EPO
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☑
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities – but staying in the network can help lower your costs.	☐
Primary care physician (PCP) required With this plan, you need to select a PCP – the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☑
Freestanding centers You may pay less when you use certain freestanding centers – health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☑
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free.Use it to save and pay for qualified medical expenses.	☐

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how EPO works

Medical Benefits

	In Network
Annual Medical Deductible	
Individual	$3,250
Family	$6,500
Ped Dental Annual Deductible - Family	Included in your medical deductible
Ped Dental Annual Deductible - Individual	Included in your medical deductible

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

**After the Annual Medical Deductible has been met.*

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit	
Individual	$9,200
Family	$18,400

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

	What You Pay for Services	
Copays ($) and Coinsurance (%) for Covered Health Care Services	**Designated Network**	**Network**
Preventive Care Services		
Preventive Care Services *Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, coinsurance or deductible.* *Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.*		No copay

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services	
	Designated Network	Network
Office Services - Sickness & Injury		
Primary Care Physician *Additional copays, deductible, or coinsurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*		$40 copay
Specialist *Additional copays, deductible, or coinsurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*		$80 copay
Telemedicine Program (Virtual Visits) *Benefits are available only when services are delivered through a Designated Virtual Network Provider for 24/7 Virtual Visit services only. You can find a 24/7 Virtual Visit Provider by contacting us at myuhc.com® or the telephone number on your ID card.*		No copay
Urgent Care Center Services		$100 copay
Emergency Care		
Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services and Emergency Transportation including Air Ambulance)		
Air Ambulance		No copay
Ground Ambulance		No copay
Emergency Department *There is no cost for health care forensic examinations performed under Public Health Law §2805-i.*		50%*
Non-Emergency Ambulance (Ground and Air Ambulance)		
Air Ambulance		No copay
Ground Ambulance		No copay

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services	
	Designated Network	Network
Inpatient Care		
Inpatient Habilitative Services (Physical, Speech & Occupational Therapy) *Limited to 60 combined visits of physical therapy, occupational therapy and speech therapy per year.* *Limits do not apply to Inpatient Habilitation Services for a mental health condition or substance use disorder.*		40%*
Inpatient Hospital for a Continuous Confinement		40%*
Inpatient Medical Visits		40%*
Physician Fees for Surgical and Medical Services - Inpatient		40%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services *Limited to 60 days per year in an Inpatient Rehabilitation Facility.* *Limits do not apply to Inpatient Rehabilitation Services for a mental health condition or substance use disorder.* *The limit for Inpatient Rehabilitation Services applies to any combination of physical therapy, occupational therapy, and speech therapy.*		40%*
Outpatient Care		
Chiropractic Services		$80 copay
Habilitative Services - Outpatient *Limited to 60 combined visits of physical therapy, occupational therapy and speech therapy per year.* *Limits do not apply to Habilitation Services for a mental health condition or substance use disorder.*		$80 copay
Home Health Care *Limited to 40 visits per year.* *Limits do not apply to Home Health Care for a mental health condition or substance use disorder.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. Home infusion counts toward home health care visit limits.*		$80 copay

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services	
	Designated Network	Network
Lab, X-Ray and Diagnostic - Outpatient - Laboratory Procedures		
Performed as Outpatient Hospital Services	No copay	50%*
Performed in a Freestanding Radiology Facility	No copay	50%*
Performed in a PCP Office	No copay	$40 copay
Performed in a Specialist Office	No copay	$80 copay
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing		
Performed as Outpatient Hospital Services		40%*
Performed in a Freestanding Radiology Facility		40%*
Performed in a PCP Office		$40 copay
Performed in a Specialist Office		$80 copay
Major Diagnostic and Imaging - Outpatient Advanced Imaging Services and Therapeutic Radiology Services		
Performed as Outpatient Hospital Services		40%*
Performed in a Freestanding Radiology Facility		40%*
Performed in a Specialist Office		$80 copay
Physician Fees for Surgical and Medical Services - Outpatient		
For services provided at an ambulatory surgical center or in a physician's office		40%*
For services provided at an outpatient hospital-based surgical center		40%*
Rehabilitation Services - Outpatient Therapy		$80 copay
Limited to 60 combined visits of physical therapy, occupational therapy and speech therapy per year.		
Limits do not apply to Rehabilitation Services for a mental health condition or substance use disorder.		
Surgery - Outpatient		
For services provided at an ambulatory surgical center or in a physician's office		40%*
For services provided at an outpatient hospital-based surgical center		40%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services	
	Designated Network	Network
Therapeutic Treatments - Outpatient		
Performed as Outpatient Hospital Services		40%*
Performed in a Freestanding Radiology Facility		$80 copay
Performed in a PCP Office		$40 copay
Performed in a Specialist Office		$80 copay
Out of Network: Limited to 10 visits per year for dialysis. *Dialysis is not covered out-of-network, except for up to 10 visits per calendar year from a non-network provider to be paid at the network level when approved in advance.*		
Supplies and Services		
Diabetic Education		$40 copay
Diabetic Equipment and Supplies, Diabetic Insulin, Diabetic Oral Anti-Diabetic Agents and Injectible Anti-Diabetic Agents *There is no cost in-network for insulin.*		$40 copay
Durable Medical Equipment and Braces		40%*
External Hearing Aids *Limited to a single purchase per hearing impaired ear every 3 years.* *Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*		40%*
Prescription Drugs Administered in Office or Outpatient Facilities		
Performed in Outpatient Facilities		40%*
Performed in a PCP Office		$40 copay
Performed in a Specialist Office		$80 copay
This includes medications given at a doctor's office, or in a covered person's home.		

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services	
	Designated Network	Network
Prosthetic Devices		
External		No copay
Internal		40%*
Limited to 1 prosthetic device per limb per lifetime.		
Limit applies to External Prosthetic Devices only.		
Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.		
Pregnancy		
Maternity and Newborn Care		
Other Maternity Services and Newborn Care	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Outpatient Donor Breast Milk		40%*
One Home Care visit is covered at no cost-sharing if mother is discharged from Hospital early.		
There is no cost for network prenatal and postnatal care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.		
Mental Health Care & Substance Related and Addictive Disorder Services		
Inpatient Hospital or Residential Facility		40%*
Intensive Behavioral Therapy (e.g. ABA Treatment for Autism Spectrum Disorder)		No copay*
Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation and Medication Assisted Treatment		No copay*
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs		No copay*
Includes Mental Health Outpatient Services provided in a Facility licensed, certified, or otherwise authorized by OMH.		
There is no cost for Network Opioid Treatment Programs.		

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services	
	Designated Network	Network
Outpatient Office Visit *There is no cost for Network Opioid Treatment Programs.*		$80 copay
Other Services		
Abortion Services		No copay
Assistive Communication Devices for Autism Spectrum Disorder		$40 copay
Clinical Trials	The amount you pay is based on where the covered health care service is provided.	
Hospice Care Inpatient Outpatient		 40%* $80 copay
Infertility Services	The amount you pay is based on where the covered health care service is provided.	
Medical Supplies		40%*
Obesity - Weight Loss Surgery		40%*
Oral Surgery	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
Reconstructive Procedures	The amount you pay is based on where the covered health care service is provided.	
Retail Health Care Clinic		$40 copay
Second and third Opinions *If you obtain a second opinion for a diagnosis of cancer from an out-of-Network provider, it will be covered at the Network Benefit level.* *Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist.* *There is no charge to you for second or third opinions requested by us.*		$80 copay
Transplantation Services[1] *Transplantation services must be received from a Designated Provider.*		40%*
Wigs *Limited to one wig per lifetime.*		40%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services	
	Designated Network	Network
Pediatric Services - Dental		
All Pediatric Dental - Benefits covered up to age 19 *Additional limits may apply. Refer to your plan documents for more information.*		
Basic Dental Services		20%*
Diagnostic Services *Limited to 1 time every 36 months for Panoramic x-rays.* *Limited to 2 evaluations (checkup exams) every 12 months.* *Limited to 2 series of films every 12 months of Bitewing x-rays.*		No copay*
Major Restorative Services		50%*
Medically Necessary Orthodontics[1] *All orthodontic treatment must be prior authorized.*		50%*
Preventive Services *Limited to 2 dental prophylaxis cleanings and fluoride treatments every 12 months.*		No copay*
Pediatric Services - Vision		
All Pediatric Vision - Benefits Covered up to age 19		
Contact Lenses/Necessary Contact Lenses *Limited to 1 fitting and evaluation every 12 months.* *Limited to a 12 month supply.* *We will pay benefits for only one vision care service. You may choose either eyeglasses (eyeglass lenses and/or eyeglass frames) or contact lenses.*		50%

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services	
	Designated Network	Network
Eyeglass Frames		
Eyeglass frames with a retail cost below $130.		50%
Eyeglass frames with a retail cost between $130-$160.		50%
Eyeglass frames with a retail cost between $160-$200.		50%
Eyeglass frames with a retail cost between $200-$250.		50%
Eyeglass frames with a retail cost greater than $250.		50%
Limited to once every 12 months.		
Eyeglass Lenses		50%
Limited to once every 12 months.		
Lens Extras		No copay
Limited to once every 12 months.		
Coverage includes polycarbonate lenses and standard scratch-resistant coating.		
Routine Vision Exam		$30 copay
Limited to once every 12 months.		

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	Broad Rx Network
Prescription Drug List	Advantage
	In Network
Annual Pharmacy Deductible	
Individual	$200
Family	See Individual Deductible

**After the Annual Pharmacy Deductible has been met.*

Annual Pharmacy Deductible

The Pharmacy Deductible is the amount you pay for pharmacy expenses per year before you begin to receive Pharmacy Benefits.

Prescription Drug Product Tier Level	Up to a 31-day supply	Up to a 90-day supply
	Retail and Specialty Pharmacy Network	**Mail Order Pharmacy****
Tier 1 $	$10	$25
Tier 2 $$	$50*	$125*
Tier 3 $$$	$90*	$225*

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.
Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.
If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

Here's an example of how the plan's costs come into play

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you – this is your **coinsurance.***

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year – copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, $15) –or **copay** – for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

*Your coinsurance may vary by service. This example is for illustrative purposes only.

Digital tools to keep you connected

Once you're a member, you can access your personalized digital tools – the **UnitedHealthcare® app** and **myuhc.com®** – these tools give you quick access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Access your health plan ID card and add your plan details to your smartphone's digital wallet
- Learn about covered preventive care
- Quickly compare cost estimates before you get care, which may help you save money

Get connected

Scan this code to download the UnitedHealthcare app or visit myuhc.com

Other important information about your benefits

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at an In-Network Retail Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The In- Network Retail Pharmacy Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from an In-Network Mail Order Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Retail Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) or pharmaceutical product(s) for which Benefits are provided as described under the Certificate first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

Certain Preventative Care Medications may be covered at zero costshare. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by an In-Network Mail Order Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how In-Network Mail Order Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through an In-Network Mail Order Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

• Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
• Certain compounded drugs.
• Diagnostic kits and products, including associated services.
• Drugs available over-the-counter, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this Certificate.
• Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
• Experimental or Investigational or Unproven Services and medications for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, you are entitled to an Appeal as described in the Utilization Review and External Appeal sections of the Certificate.
• General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
• Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
• Prescription Drug Products used for cosmetic or convenience purposes.
• Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
• Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill, except for assistive communication devices.
• We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.
• We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

UnitedHealthcare does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us such as letters in others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (**Vietnamese**), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (**Tagalog**), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русский (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة العضوية الخاصة بك.

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (**French**), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (**Polish**), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (**Portuguese**), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (**Italian**), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (**German**) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (**Hmong**), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά **(Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

PAKDAAR: Nu saritaem ti Ilocano (**Ilocano**), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (**Somali**), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

ગુજરાતી **(Gujarati)**: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપ્ય છે. મહેરબાની કરી તમારા આઇડી કાડડની સૂચિપર આપેલો સેભ્યે માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

United Healthcare®

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.whyuhc.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 or call 1-800-444-6222 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $7,250 Individual / $14,500 Family Per Policy year.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	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 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?	Network: $7,250 Individual / $14,500 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, 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.whyuhc.com/welcometouhc or call 1-800-444-6222 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
		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	0% coinsurance	Not Covered	Virtual visits (Telehealth) - 0% coinsurance per visit by a Designated Virtual Network Provider. No virtual coverage for out-of-Network. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Specialist visit	0% coinsurance	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	Not Covered	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)	Office Lab: 0% coinsurance Free Standing Lab: 0% coinsurance Hospital Lab: 0% coinsurance Free Standing X-ray: 0% coinsurance Hospital X-ray: 0% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing: 0% coinsurance Hospital: 0% coinsurance	Not Covered	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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.whyuhc.com/welcometouhc	Tier 1	Retail: $0 copay Mail-Order: $0 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply If you use a out of network-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2	Retail: $0 copay Mail-Order: $0 copay	Not Covered	
	Tier 3	Retail: $0 copay Mail-Order: $0 copay	Not Covered	
	Tier 4	Not Applicable	Not Covered	Tier not applicable for this plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Ctr: 0% coinsurance Hospital: 0% coinsurance	Not Covered	None
	Physician/surgeon fees	0% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance *	*Network Deductible applies
	Emergency medical transportation	0% coinsurance	0% coinsurance *	*Network Deductible applies
	Urgent care	0% coinsurance	Not Covered	If you receive services in addition to Urgent Care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not Covered	None
	Physician/surgeon fees	0% coinsurance	Not Covered	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 mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	Not Covered	Network partial hospitalization/intensive outpatient treatment/high intensity outpatient: 0% coinsurance Intensive Behavior Therapy (ABA): 0% coinsurance
	Inpatient services	0% coinsurance	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	0% coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	0% coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	Limited to 40 visits per policy year.
	Rehabilitation services	0% coinsurance	Not Covered	Limits per condition per policy year: Physical, Speech and Occupational therapy combined limit 60 visits.
	Habilitation services	0% coinsurance	Not Covered	Limits per condition per policy year: Physical, Speech and Occupational therapy combined limit 60 visits.
	Skilled nursing care	0% coinsurance	Not Covered	None
	Durable medical equipment	0% coinsurance	Not Covered	Preauthorization required for DME over $500 or there is no coverage
	Hospice services	0% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to 1 exam per 12 month period. Covered for individuals up to the age of 19.
	Children's glasses	50% coinsurance	Not Covered	One pair every 12 months. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Covered for individuals up to the age of 19.
	Children's dental check-up	0% coinsurance	Not Covered	Cleanings are covered 2 times per 12 months. Additional limitations may apply. Covered for individuals up to the age of 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.)		
• Acupuncture • Long-Term Care • Routine Eye Care (Adult)	• Cosmetic Surgery • Non-emergency care when travelling outside - the U.S.	• Dental Care (Adult) • 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.)		
• Bariatric Surgery • Infertility Treatment – Cycle limits may apply.	• Chiropractic (Manipulative) Care • Private duty nursing	• Hearing aids

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or you may also contact us at 1-800-782-3740. 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: your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the New York Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov/index.htm. .

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 1-800-782-3740.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-782-3740.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-782-3740.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-782-3740 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-782-3740.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-782-3740.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-782-3740.

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	**$7,250**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$7,250
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,310**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$7,250**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$1,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,700**

Mia's Simple Fracture

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

The plan's overall deductible	**$7,250**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

EPO plan details, all in one place

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	EPO
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☑
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities – but staying in the network can help lower your costs.	☐
Primary care physician (PCP) required With this plan, you need to select a PCP – the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☐
Freestanding centers You may pay less when you use certain freestanding centers – health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☑
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free.Use it to save and pay for qualified medical expenses.	☑

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how EPO works

Medical Benefits

	In Network
Annual Medical Deductible	
Single Coverage	$7,250
Family Coverage	$14,500
Ped Dental Annual Deductible - Family	Included in your medical deductible
Ped Dental Annual Deductible - Individual	Included in your medical deductible

No one in the family is eligible for benefits until the family coverage deductible is met.

**After the Annual Medical Deductible has been met.*

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit	
Individual	$7,250
Family	$14,500

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Preventive Care Services	
Preventive Care Services *Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, coinsurance or deductible.* *Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.*	No copay

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Office Services - Sickness & Injury	
Primary Care Physician *Additional copays, deductible, or coinsurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	No copay*
Specialist *Additional copays, deductible, or coinsurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	No copay*
Telemedicine Program (Virtual Visits) *Benefits are available only when services are delivered through a Designated Virtual Network Provider for 24/7 Virtual Visit services only. You can find a 24/7 Virtual Visit Provider by contacting us at myuhc.com® or the telephone number on your ID card.*	No copay*
Urgent Care Center Services	No copay*
Emergency Care	
Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services and Emergency Transportation including Air Ambulance)	
Air Ambulance	No copay*
Ground Ambulance	No copay*
Emergency Department *There is no cost for health care forensic examinations performed under Public Health Law §2805-i.*	No copay*
Non-Emergency Ambulance (Ground and Air Ambulance)	
Air Ambulance	No copay*
Ground Ambulance	No copay*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services Network
Inpatient Care	
Inpatient Habilitative Services (Physical, Speech & Occupational Therapy) *Limited to 60 combined visits of physical therapy, occupational therapy and speech therapy per year.* *Limits do not apply to Inpatient Habilitation Services for a mental health condition or substance use disorder.*	No copay*
Inpatient Hospital for a Continuous Confinement	No copay*
Inpatient Medical Visits	No copay*
Physician Fees for Surgical and Medical Services - Inpatient	No copay*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services *Limited to 60 days per year in an Inpatient Rehabilitation Facility.* *Limits do not apply to Inpatient Rehabilitation Services for a mental health condition or substance use disorder.* *The limit for Inpatient Rehabilitation Services applies to any combination of physical therapy, occupational therapy, and speech therapy.*	No copay*
Outpatient Care	
Chiropractic Services	No copay*
Habilitative Services - Outpatient *Limited to 60 combined visits of physical therapy, occupational therapy and speech therapy per year.* *Limits do not apply to Habilitation Services for a mental health condition or substance use disorder.*	No copay*
Home Health Care *Limited to 40 visits per year.* *Limits do not apply to Home Health Care for a mental health condition or substance use disorder.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. Home infusion counts toward home health care visit limits.*	No copay*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services Network
Lab, X-Ray and Diagnostic - Outpatient - Laboratory Procedures	
Performed as Outpatient Hospital Services	No copay*
Performed in a Freestanding Radiology Facility	No copay*
Performed in a PCP Office	No copay*
Performed in a Specialist Office	No copay*
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing	
Performed as Outpatient Hospital Services	No copay*
Performed in a Freestanding Radiology Facility	No copay*
Performed in a PCP Office	No copay*
Performed in a Specialist Office	No copay*
Major Diagnostic and Imaging - Outpatient Advanced Imaging Services and Therapeutic Radiology Services	
Performed as Outpatient Hospital Services	No copay*
Performed in a Freestanding Radiology Facility	No copay*
Performed in a Specialist Office	No copay*
Physician Fees for Surgical and Medical Services - Outpatient	
For services provided at an ambulatory surgical center or in a physician's office	No copay*
For services provided at an outpatient hospital-based surgical center	No copay*
Rehabilitation Services - Outpatient Therapy *Limited to 60 combined visits of physical therapy, occupational therapy and speech therapy per year.* *Limits do not apply to Rehabilitation Services for a mental health condition or substance use disorder.*	No copay*
Surgery - Outpatient	
For services provided at an ambulatory surgical center or in a physician's office	No copay*
For services provided at an outpatient hospital-based surgical center	No copay*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services Network
Therapeutic Treatments - Outpatient	
Performed as Outpatient Hospital Services	No copay*
Performed in a Freestanding Radiology Facility	No copay*
Performed in a PCP Office	No copay*
Performed in a Specialist Office	No copay*
Out of Network: Limited to 10 visits per year for dialysis. *Dialysis is not covered out-of-network, except for up to 10 visits per calendar year from a non-network provider to be paid at the network level when approved in advance.*	
Supplies and Services	
Diabetic Education	No copay*
Diabetic Equipment and Supplies, Diabetic Insulin, Diabetic Oral Anti-Diabetic Agents and Injectible Anti-Diabetic Agents *There is no cost in-network for insulin.*	No copay*
Durable Medical Equipment and Braces	No copay*
External Hearing Aids *Limited to a single purchase per hearing impaired ear every 3 years.* *Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*	No copay*
Prescription Drugs Administered in Office or Outpatient Facilities	
Performed in Outpatient Facilities	No copay*
Performed in a PCP Office	No copay*
Performed in a Specialist Office	No copay*
This includes medications given at a doctor's office, or in a covered person's home.	

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services Network
Prosthetic Devices	
External	No copay*
Internal	No copay*
Limited to 1 prosthetic device per limb per lifetime.	
Limit applies to External Prosthetic Devices only.	
Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.	
Pregnancy	
Maternity and Newborn Care	
Other Maternity Services and Newborn Care	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.
Outpatient Donor Breast Milk	No copay*
One Home Care visit is covered at no cost-sharing if mother is discharged from Hospital early.	
There is no cost for network prenatal and postnatal care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	
Mental Health Care & Substance Related and Addictive Disorder Services	
Inpatient Hospital or Residential Facility	No copay*
Intensive Behavioral Therapy (e.g. ABA Treatment for Autism Spectrum Disorder)	No copay*
Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation and Medication Assisted Treatment	No copay*
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs *Includes Mental Health Outpatient Services provided in a Facility licensed, certified, or otherwise authorized by OMH.* *There is no cost for Network Opioid Treatment Programs, after deductible.*	No copay*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Outpatient Office Visit *There is no cost for Network Opioid Treatment Programs, after deductible has been met.*	No copay*
Other Services	
Abortion Services	No copay*
Assistive Communication Devices for Autism Spectrum Disorder	No copay*
Clinical Trials	The amount you pay is based on where the covered health care service is provided.
Hospice Care	
Inpatient	No copay*
Outpatient	No copay*
Infertility Services	The amount you pay is based on where the covered health care service is provided.
Medical Supplies	No copay*
Obesity - Weight Loss Surgery	No copay*
Oral Surgery	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.
Reconstructive Procedures	The amount you pay is based on where the covered health care service is provided.
Retail Health Care Clinic	No copay*
Second and third Opinions *If you obtain a second opinion for a diagnosis of cancer from an out-of-Network provider, it will be covered at the Network Benefit level.* *Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist.* *There is no charge to you for second or third opinions requested by us.*	No copay*
Transplantation Services[1] *Transplantation services must be received from a Designated Provider.*	No copay*
Wigs *Limited to one wig per lifetime.*	No copay*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services Network
Pediatric Services - Dental	
All Pediatric Dental - Benefits covered up to age 19 *Additional limits may apply. Refer to your plan documents for more information.*	
Basic Dental Services	20%*
Diagnostic Services *Limited to 1 time every 36 months for Panoramic x-rays.* *Limited to 2 evaluations (checkup exams) every 12 months.* *Limited to 2 series of films every 12 months of Bitewing x-rays.*	No copay*
Major Restorative Services	50%*
Medically Necessary Orthodontics[1] *All orthodontic treatment must be prior authorized.*	50%*
Preventive Services *Limited to 2 dental prophylaxis cleanings and fluoride treatments every 12 months.*	No copay*
Pediatric Services - Vision	
All Pediatric Vision - Benefits Covered up to age 19	
Contact Lenses/Necessary Contact Lenses *Limited to 1 fitting and evaluation every 12 months.* *Limited to a 12 month supply.* *We will pay benefits for only one vision care service. You may choose either eyeglasses (eyeglass lenses and/or eyeglass frames) or contact lenses.*	50%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services Network
Eyeglass Frames	
Eyeglass frames with a retail cost below $130.	50%*
Eyeglass frames with a retail cost between $130-$160.	50%*
Eyeglass frames with a retail cost between $160-$200.	50%*
Eyeglass frames with a retail cost between $200-$250.	50%*
Eyeglass frames with a retail cost greater than $250.	50%*
Limited to once every 12 months.	
Eyeglass Lenses *Limited to once every 12 months.*	50%*
Lens Extras *Limited to once every 12 months.* *Coverage includes polycarbonate lenses and standard scratch-resistant coating.*	No copay*
Routine Vision Exam *Limited to once every 12 months.*	No copay

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	Broad Rx Network
Prescription Drug List	Advantage
	In Network
Annual Pharmacy Deductible	
Individual	See the Annual Medical Deductible section
Family	See the Annual Medical Deductible section
Annual Deductible *The Pharmacy Deductible is the amount you pay for pharmacy expenses per year before you begin to receive Pharmacy Benefits.*	

Prescription Drug Product Tier Level	Up to a 31-day supply	Up to a 90-day supply
	Retail and Specialty Pharmacy Network	**Mail Order Pharmacy****
Tier 1 **$**	No copay*	No copay*
Tier 2 **$$**	No copay*	No copay*
Tier 3 **$$$**	No copay*	No copay*

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.
Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.
If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

Here's an example of how the plan's costs come into play

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you – this is your **coinsurance.***

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year – copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, $15) –or **copay** – for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

*Your coinsurance may vary by service. This example is for illustrative purposes only.

Digital tools to keep you connected

Once you're a member, you can access your personalized digital tools – the **UnitedHealthcare® app** and **myuhc.com®** – these tools give you quick access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Access your health plan ID card and add your plan details to your smartphone's digital wallet
- Learn about covered preventive care
- Quickly compare cost estimates before you get care, which may help you save money

Get connected

Scan this code to download the UnitedHealthcare app or visit myuhc.com

Other important information about your benefits

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at an In-Network Retail Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The In- Network Retail Pharmacy Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from an In-Network Mail Order Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Retail Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) or pharmaceutical product(s) for which Benefits are provided as described under the Certificate first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

Certain Preventative Care Medications may be covered at zero costshare. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by an In-Network Mail Order Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how In-Network Mail Order Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through an In-Network Mail Order Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

• Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
• Certain compounded drugs.
• Diagnostic kits and products, including associated services.
• Drugs available over-the-counter, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this Certificate.
• Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
• Experimental or Investigational or Unproven Services and medications for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, you are entitled to an Appeal as described in the Utilization Review and External Appeal sections of the Certificate.
• General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
• Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
• Prescription Drug Products used for cosmetic or convenience purposes.
• Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
• Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill, except for assistive communication devices.
• We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.
• We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

UnitedHealthcare does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us such as letters in others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (**Vietnamese**), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (**Tagalog**), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русский (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة العضوية الخاصة بك.

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (**French**), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (**Polish**), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (**Portuguese**), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (**Italian**), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (**German**) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (**Hmong**), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά **(Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

PAKDAAR: Nu saritaem ti Ilocano (**Ilocano**), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (**Somali**), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

ગુજરાતી **(Gujarati)**: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપ્ય છે. મહેરબાની કરી તમારા આઇડી કાડડની સૂચિપર આપેલો સેભ્યે માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

United Healthcare®

The Employee Assistance Program (EAP)

Someone you can talk to, 24/7

Connect to caring, confidential support anytime to help you:

- Improve relationships
- Find support for child and elder care
- Seek recovery for substance use issues

Learn more at **uhc.com/eap** or call the member phone number on your health plan ID card

The material provided through the Employee Assistance Program (EAP) is for informational purposes only. EAP staff cannot diagnose problems or suggest treatment. EAP is not a substitute for your doctor's care. Employees are encouraged to discuss with their doctor how the information provided may be right for them. Your health information is kept confidential in accordance with the law. EAP is not an insurance program and may be discontinued at any time. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against UnitedHealthcare or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply.

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See a doctor 24/7

With 24/7 Virtual Visits, you can connect to a doctor by phone or video* through myuhc.com® or the UnitedHealthcare® app.

May be used for common medical conditions and you can even get a prescription**

- Allergies
- Bronchitis
- Pinkeye
- Rashes
- Sore throats
- And more

Telehealth Visits with Your Doctor***

- Stay connected with your local doctor through live audio/video chat
- Can be used for routine, chronic, or follow-up care

* Data rates may apply.

** Certain prescriptions may not be available, and other restrictions may apply.

*** Not available with all providers.

See a provider anywhere, anytime

Through Behavioral Health virtual care, you may have a real-time, audio- and video-enabled session with a behavioral health provider

Use a behavioral health virtual visit for needs such as:

- Anxiety
- Bipolar disorder
- Depression
- Neuro-development disorders
- Substance disorders

NOTE: There is a cost for this service

One Pass Select Gym Discount Program

Employees can enroll in One Pass Select through UHC Rewards on the UHC App or myuhc.com

One Pass Select is a subscription-based fitness and well-being program that supports a healthier lifestyle, providing access to over 16,000 gyms nationwide.

Classic	Standard	Premium	Elite
$29 / month	$64 / month	$99 / month	$144 / month
LA Fitness	CycleBar	Lifetime Fitness	CrossFit Forging Elite Fitness
planet fitness	Lifetime Fitness	orangetheory Fitness	Lifetime Fitness
Crunch Fitness	pure barre	Club Pilates	F45
Anytime Fitness	Row House	Rumble	The Exercise Coach
snap fitness 24/7	Stretch Lab	Crunch Fitness	Eat the Frog Fitness

- No long-term contracts or annual gym registration fees
- Flexible fitness options and the ability to use locations nationwide (not limited to 1 gym)
- The ability to add up to 4 family members (ages 18+) at a 10% monthly discount
- Option to change tiers monthly
- Cancel with 30-day notice

Note: Monthly membership not prorated.

UnitedHealthcare Rewards

With **UnitedHealthcare Rewards**, you can earn rewards for reaching daily goals and completing one-time activities.

One-time reward activities:

- Complete a health survey
- Get a biometric screening
- Go paperless
- Connect a tracker

Reaching daily goals:

- Daily activity – Goal 1
  (15+ minutes or walk 5K+ steps)
- Daily activity – Goal 2
  (30+ minutes or walk 10K+ steps)
- Sleep tracking (track 14 nights of sleep)

With daily participation, there's a potential to earn up to:

$300 embedded in most fully-insured plans

OR

$1,000 Included with select plan designs

Earnings are per participant, per year.

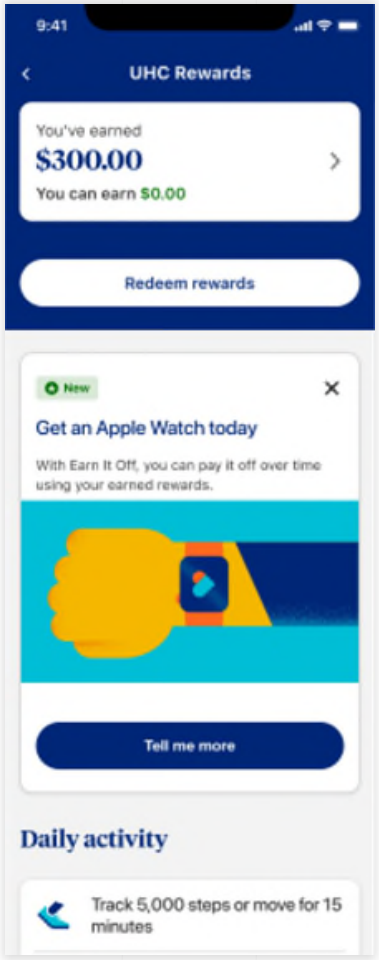
Earn It Off

Members can get an **Apple Watch** today and pay it off with the rewards they earn over 12 months

Get an Apple Watch
Members choose an Apple Watch and pay a lower — or $0 — upfront cost today

Earn rewards
Every dollar members earn with UHC Rewards, including any already in their account, is put toward their Earn It Off total

Pay off the balance
Members pay off the cost of their Apple Watch over 12 months



Care Cash

Applies to all Non-HSA plans (except HNY), effective 1/1/2025

Care Cash provides financial help to pay for health care expenses. The preloaded debit card can be used for specific network providers, which may lead to savings.

Care Cash most-used benefits[1]

- Premium Care Physicians
- Behavioral health providers
- Urgent care facilities

What you should know

- **$200** is provided for the year for individual coverage
- **$500** is provided for the year for family coverage
- Remaining card balances is rolled over each plan year*
- New funds are reloaded each plan year*

maintained

[1] Book of Business, October 2020 through March 31, 2021.

Care Cash provides a pre-loaded debit card which can be used for certain health care expenses. If the card is used for ineligible 213(d) expenses, individuals may incur tax obligations and should consult an appropriate tax professional to determine if they have such obligations. The information provided in connection with Care Cash is for general informational purposes only and is not intended to be nor should be construed as medical advice. Individuals should consult an appropriate health care professional to determine what may be right for them.

Earn up to $400 Annually with the Sweat Equity Program

You may earn up to $200 every 6 months for meeting program exercise requirements.

- Complete 50 workouts to qualify
  - Gym visits
  - Classes
  - Fitness events
  - Any mix of the above options
- Complete in a 6-month period
- Submit a reimbursement form to receive your earnings

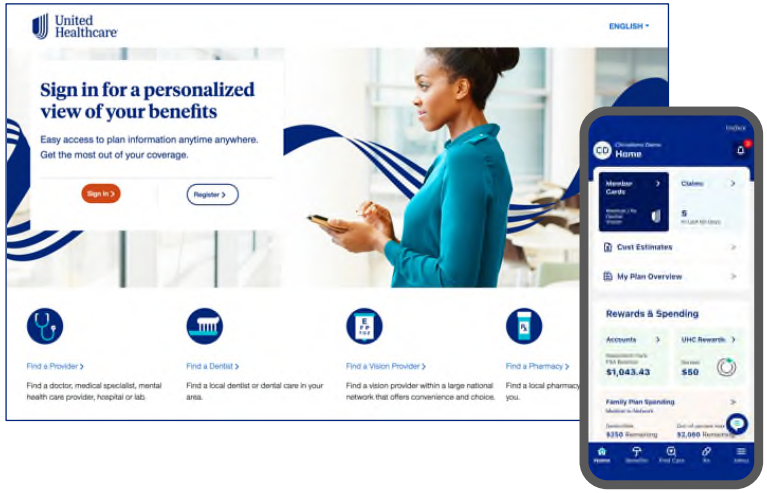
Two convenient ways to access your plan

With myuhc.com®, you can:

- Find and estimate costs
- Search network providers
- Check on claims and plan balances

On the UnitedHealthcare® app, also:

- Video chat with a provider 24/7
- Access your health plan ID card



Download the app

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Members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the website or mobile application terms of use under Find Care & Costs section.]

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

New York Member Enrollment Form – OHI

MAILING ADDRESS: P. O. Box 29142, Hot Springs, AR 71903 • 1-800-444-6222

UnitedHealthcare Oxford

THANK YOU FOR CHOOSING AN OXFORD PRODUCT
FOR YOU AND YOUR FAMILY.

IMPORTANT:

PLEASE PRINT AND PRESS DOWN FIRMLY WHEN COMPLETING THIS FORM.

IN ORDER TO PROCESS THE ATTACHED FORM AND BEGIN COVERAGE, ALL FIELDS MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.

BE SURE TO:

- @ Use only blue or black ballpoint pen
- @ Enter all dates using the MM/DD/YYYY format
- @ Employer and employee signatures are required
- @ List any coordinating coverage (coverage in addition to this coverage)
- @ List any coverage you had prior to this coverage
- @ Attach disability paperwork, if applicable
- @ Check “young adult” in the child column if the child is under the age of 30, eligible, and enrolling onto the young adult option. The young adult will also need to list their qualifying event, address and signature.
- @ Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation

IF YOU HAVE ANY QUESTIONS,
PLEASE FEEL FREE TO CALL CUSTOMER SERVICE AT
1-800-444-6222

New York Member Enrollment Form – OHI

UnitedHealthcare Oxford

MAILING ADDRESS: P. O. Box 29142, Hot Springs, AR 71903 • 1-800-444-6222

A. Group Information (To be completed by the employer)

Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY

Group Number	Group Name	Plan CSP/Plan ID	Billing Group	Date of Hire	Effective Date	Occupation
1299345	Kulanu Academy			/ /	/ /	

☐ On Leave of Absence ☐ Retired ☐ Union Employee

COBRA/Young Adult/SC Qualifying Event — Event Date / /

Employer Signature X — Date / /

B. Applicant Details (To be completed by the employee)

	Employee/Subscriber	Spouse	Child	Child
Social Security Number:				
Last Name:				
First Name, Middle Initial:				
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender: (Check appropriate boxes.)	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Check all that apply:		☐ Domestic Partner	☐ Young Adult	☐ Young Adult

C. Coordination of Benefits

	Employee/Subscriber	Spouse	Child	Child
Medicare Coverage — Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all — Policy Number: Carrier: Policy Holder: Effective Date: / / Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all — Policy Number: Carrier: Policy Holder: Effective Date:	/ /	/ /	/ /	/ /

I understand that my enrollments and benefits are in accordance with those described in the Oxford Health Insurance Certificate. I understand that, in order to receive in-network benefits, I and any enrolled dependents must seek care through our Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician with an authorized referral from the primary care physician if required. I further understand that if I do not adhere to these requirements, I will be eligible only for out-of-network health insurance coverage under the terms of the Certificate. **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.** I authorize any health provider or insurer to furnish Oxford any records concerning me or any enrolled member of my family for whom information is requested.

Employee's/Young Adult's Address	(Apt #)	Preferred Phone: ☐ Home ☐ Cell ☐ Work _____
City / State / ZIP Code		Alternate Phone: ☐ Home ☐ Cell ☐ Work _____
Email Address:		Employee's/Young Adult's Signature X — Date / /

UnitedHealthcare Oxford

Addition/Termination Change Form

P. O. Box 29142, Hot Springs, AR 71903 ▪ 1-800-444-6222

Please print neatly using black or blue ballpoint pen

ALL DATES MUST BE: MM/DD/YYYY

A. Employer/Employee Information (To be completed by the employer)

Group ID Number: 1299345	Group Name: Kulanu Academy
Employee Insurance ID Number:	Employer Signature X / Date / /
Employee Name:	

B. Transaction	Effective Date	Required Information
☐ **Termination**	/ /	**Who:** ☐ Employee ☐ Spouse/Partner ☐ Dependent(s) ☐ NY Young Adult **Reason:** ☐ Left Employer ☐ Discontinue COBRA ☐ Switched Plans ☐ Discontinue NY Young Adult ☐ Other:
☐ **Change** Address changes can be done online or by calling Oxford.	/ /	**Who:** Last Name: First Name: Effective Date: / / Date of Birth: / / Other: SS#: Middle Intial: Gender: ☐ M ☐ F
☐ **COBRA or State Continuation**	/ /	**Who:** ☐ Employee ☐ Spouse/Partner* ☐ Dependent(s)* **Reason:** ☐ Left Employer ☐ Hours Reduction ☐ Other: Date of Event: / / *A **New Member Enrollment Form** is required for: Loss of Dependent Status, Divorce/Separation, or Death of Subscriber.
☐ **Transfer** Complete entire section	/ /	New Plan CSP/Plan ID: New Billing Group: Reason: Retiree Drug Subsidy: ☐ Yes ☐ No Actively Working: ☐ Yes ☐ No Enrolled in Medicare Part: ☐ A ☐ B ☐ D
☐ **Addition** Complete WHO, REASON and SECTION C below	/ /	**Who:** ☐ Spouse ☐ Civil Union ☐ Domestic Partner ☐ Dependent(s) **Reason:** ☐ Open Enrollment ☐ Loss of Coverage ☐ Birth/Adoption ☐ Other: ☐ Date of Marriage ☐ Date of Civil Union ☐ Date of Partnership

C. Additional Information	Spouse	Dependent	Dependent
Social Security Number:			
Last Name:			
First Name, Middle Initial:			
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /
Gender and Disability Status:	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient, check "Yes".)	☐ Yes	☐ Yes	☐ Yes
Check all that apply:	☐ Actively employed ☐ Not actively employed	☐ Full-time Student (Age 19 - 23)	☐ Full-time Student (Age 19 - 23)
Prior Carrier What coverage you had prior to this. Policy Number: Carrier: From Date: Through Date:	/ / / /	/ / / /	/ / / /

D. Coordination of Benefits		Spouse	Dependent	Dependent
Medicare	Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all Effective Date: / /	Policy Number: Carrier: Policy Holder: Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number: Carrier: Policy Holder: Effective Date:	/ /	/ /	/ /

ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR INSURANCE IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES

Employee Signature X _____ Date / /

PAYCHEX

Payroll | Benefits | HR | Insurance

The Power of Simplicity