



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, call 1-800-499-1275 or visit Our website at www.univerahealthcare.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.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Out-of-Network: \$250 Individual/\$500 Family	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	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 https://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?	In-Network: \$1,000 Individual/\$2,000 Family; Out-of-Network: \$2,000 Individual/\$4,000 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?	Costs for 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.univerahealthcare.com or call 1-800-499-1275 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
		In-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	\$20 Copay /visit No Charge for Members to age 19	20% Coinsurance	None Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
	Specialist visit	\$20 Copay /visit	20% Coinsurance	
	Preventive care/screening/immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge	Adult Physical: Not Covered Adult Immunizations: Not Covered Well Child Visit: 20% 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. 1 Exam per calendar year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: \$20 Copay /visit Blood Work: No Charge	X-Ray: 20% Coinsurance Blood Work: 20% Coinsurance	None Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
	Imaging (CT/PET scans, MRIs)	\$20 Copay /visit	20% Coinsurance	
prescription drug coverage PBD SBC is attached separately	Tier 1 (Generic drugs)	Not Covered	Not Covered	None
	Tier 2 (Preferred brand drugs)	Not Covered	Not Covered	
	Tier 3 (Non-preferred brand drugs)	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$75 Copay	20% Coinsurance	None Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
	Physician/surgeon fees	No Charge	20% Coinsurance	

* For more information about limitations and exceptions, see [plan](#) or policy document at www.univerahealthcare.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$75 Copay /visit	\$75 Copay /visit	None Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
	Emergency medical transportation	\$50 Copay /visit	\$50 Copay /visit Deductible does not apply	None Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
	Urgent care	\$20 Copay /visit	20% Coinsurance	None Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% Coinsurance	None Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
	Physician/surgeon fees	No Charge	20% Coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 Copay /visit	20% Coinsurance	None
	Inpatient services	No Charge	20% Coinsurance	
If you are pregnant	Office visits	No Charge	20% Coinsurance	None Cost sharing does not apply for preventive services .
	Childbirth/delivery professional services	No Charge	20% Coinsurance	
	Childbirth/delivery facility services	No Charge	20% Coinsurance	

* For more information about limitations and exceptions, see [plan](#) or policy document at www.univerahealthcare.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	\$20 Copay	20% Coinsurance	In-network 100 Visits per year limit. The visit limit does not apply to Home Health Care for a mental health condition or substance use disorder.
	Rehabilitation services	\$20 Copay /visit	20% Coinsurance	20 Visits per year limit. The visit limit does not apply to Rehabilitation Services for a mental health condition or substance use disorder.
	Habilitation services	\$20 Copay /visit	20% Coinsurance	20 Visits per year limit. The visit limit does not apply to Habilitation Services for a mental health condition or substance use disorder.
	Skilled nursing care	No Charge	20% Coinsurance	50 Days per year limit. The visit limit does not apply to Skilled Nursing Care for a mental health condition or substance use disorder.
	Durable medical equipment	20% Coinsurance	50% Coinsurance	None
	Hospice services	No Charge	20% Coinsurance	210 Days per year limit Family bereavement counseling limited to 5 Visits per year
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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) |
| • Dental care (Child) | • Hearing aids | • Long-term care |
| • Prescription Drugs | • Private-duty nursing | • Routine eye care (Adult) |
| • Routine eye care (Child) | • 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.)

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|--|---------------------|-------------------------|
| • Bariatric surgery | • Chiropractic care | • Infertility treatment |
| • Non-emergency care when traveling outside the U.S. | | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the phone number on Your ID card or www.univerahealthcare.com; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc> and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

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](#).

-----*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	\$0
■ Copayment	\$20
■ Hospital (facility) copayment	\$0
■ 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$40
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$30
The total Peg would pay is	\$70

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Copayment	\$20
■ Hospital (facility) copayment	\$0
■ 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$120
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$100
The total Joe would pay is	\$220

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Copayment	\$20
■ Hospital (facility) copayment	\$0
■ 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$230
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$290

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, gender identity, or sex (consistent with the scope of sex discrimination as described at 45CFR section 92.10(a)(2)). The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, gender identity, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, gender identity, or sex; you can file a grievance with the Health Plan's Section 1557 Coordinator at:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Email: Advocacy.Department@UniveraHealthcare.com
Telephone number: 1-800-614-6575
TTY number: 1-800-662-1220
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at Univera Healthcare's website: www.Univerahealthcare.com

Notice of Availability of Language Assistance Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. To access these services, please call us at 1-877-687-6651 (TTY: 1-800-662-1220).

ATENCIÓN: Si habla español, tiene disponible servicios gratuitos de asistencia lingüística. También hay disponible de manera gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Para acceder a estos servicios, llámenos al 1-877-687-6651 (TTY: 1-800-662-1220).

انتباه: إذا كنت تتحدث العربية فإن خدمات مساعدة اللغة المجانية مُتاحة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتيسقات يسهل الوصول إليها مجاناً. للوصول إلى هذه الخدمات، يرجى الاتصال بنا على الرقم 1-877-687-6651 (الهاتف النصي: 1-800-662-1220)

注意：如果您說中文，我們可以為您提供免費的語言幫助。我們也可以為您免費提供適當的輔助工具和服務，以無障礙格式提供資訊。要獲得這些服務，請撥打 1-877-687-6651 (TTY : 1-800-662-1220) 。

ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services supplémentaires appropriés pour fournir des informations dans des formats accessibles sont aussi disponibles gratuitement. Pour accéder à ces services, veuillez nous appeler au 1 877 687 6651 (TTY [ATS] : 1 800 662 1220).

দুটি আকর্ষণ আপনি যদি বাংলাতে কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধি অ্যাসিসিযোগ্য ফরম্যাটে তথ্য দিনের জন্য উপযুসিহারক সাহায্য এবং পিরেরষবালি ও বিনামূল্যে উপলব্ধি এই পিরেরষবালি অ্যাসিসি করার জন্য, অনুহি কের আখাডের 1-877-687-6651 (TTY: 1-800-662-1220) নরির কল করনি।

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги языковой поддержки. Также бесплатно доступны соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах. Чтобы воспользоваться этими услугами, позвоните нам по номеру 1-877-687-6651 (TTY: 1-800-662-1220).

ध्यान दिनुहोस्: तपाईं नेपाली बोलिनुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू तपाईंका लागि उपलब्ध छन्। सुलभ ढाँचाहरू मा जानकारी दिन गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पिलिनि नःशुल्क उपलब्ध छन्। यी सेवाहरू उपयाेग गर्न, कृपया सामीलाई 1-877-687-6651 (TTY: 1-800-662-1220) मा फोन गर्नुहोस्।

УВАГА: Якщо Ви говорите українською, Вам доступні безкоштовні послуги мовної підтримки. Відповідні допоміжні засоби та послуги для надання інформації в доступних форматах також надаються безкоштовно. Щоб скористатися цими послугами, зателефонуйте нам за номером: 1-877-687-6651 (TTY [Телетайп]: 1-800-662-1220).

<p>FIRO-GAAR AH: Haddii aad ku hadashid Soomaali, adeegyada caawimaada luuqadda oo bilaashka ah ayaad helaysoo. Agabka caawimaada naafada iyo adeegyada ku habboon oo lagu bixinaayo macluumaadka qaabab la helo karo ayaa sidoo kale lagu heli karaa bilaa lacag. Si loo helo adeegyadaan, fadlan naga soo wac 1-877-687-6651 (TTY: 1-800-662-1220).</p>
<p>ဟတ်ဘူဟ်သး- နမ့် ကတိအဲကလံးကျိန်န့ဉ်, တၢ်တိစါမၤတၢ်ကျိန် တၢ်မၤတၢ်မၤ အကလိအိဉ်လၢနဂီၢ် လၢနမၤန့ၢ်အိၤသ့လီၤ. တၢ်မၤတၢ်တၢ်န့ၢ်ဟ့ၣ်မိၤဒီး တၢ်မၤတၢ်တၢ်မၤ လၢအဘၣ်ဘျိးဘၣ်ဒါတဖၣ် ကဟ့ၣ်စိစိ တၢ်ဂံၢ် တၢ်ကျိၤ လၢကျိၤကျဲလၢတၢ်ဂံၢ်လိၤမၤန့ၢ်အိၤသ့တဖၣ် ၈ ကိ အိဉ်လၢနမၤန့ၢ်အိၤသ့ လၢတလိဉ်ဟ့ၣ်အယုတၢ်န့ဉ်လီၤ. လၢကမၤန့ၢ်တၢ်မၤတၢ်မၤတဖၣ်အံၤအဂီၢ်, ထးစ့ၣ်ပုဖၣ် 1-877-687-6651 (TTY: 1-800-662-1220).</p>
<p>သတိပရန်- သင် မြန်မာ ပြောဆိုလျှင် ဘာသာစကားအကုစုအညီ ဝန်ဆောင်ပေးမှုများကို သင့်အတွက်အခမဲ့ ရရှိနိုင်ပါသည်။ မသန်စွမ်းသူ များ အသုံးပြုနိုင်သည့် ဖောမတ်များဖြင့် အချက်အလက်များ ဖြစ်ပေါ်လာသည့်အတွက်လျှော့ပေးသော ထောက်ပံ့မှုများဖြင့် ဝန်ဆောင်ပေးမှုများကိုလည်း အခမဲ့ရရှိပါသည်။ ဤဝန်ဆောင်ပေးမှုများကိုရရှိရန် ကိုယ်တိုင်ကို 1-877-687-6651 (TTY- 1-800-662-1220) သို့ ဖုန်းခေါ်ဆိုပါ။</p>
<p>CHÚ Y: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Để sử dụng các dịch vụ này, vui lòng gọi cho chúng tôi theo số 1-877-687-6651 (TTY: 1-800-662-1220).</p>
<p>ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis disponib pou ou. Éd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòm aksesib yo disponib tou gratis. Pou jwenn aksè nan sèvis sa yo, tanpri rele nou nan 1-877-687-6651 (TTY: 1-800-662-1220).</p>
<p>توجه: اگر بھ زبان دری صحبت می کنید، خدمات کمک زبان رایگان برای شما قابل دسترس است. کمک امدادی مناسب و خدمات برای دسترسی به معلومات در فرمت میسر بصورت مجانی ارائه می شود. برای دسترسی به این خدمات، با این شماره ها تماس حاصل کنید (TTY: 1-800-662-1220) 1-877-687-6651</p>
<p>TAHADHARI: Ikiwa unazungumza Kiswahili, huduma za usaidizi wa lugha bila malipo zinapatikana kwa ajili yako. Misaada ya ziada inayofaa na huduma za kutoa habari katika miundo inayofikika zinapatikana pia bila malipo Ili kupata huduma hizi, tafadhali tujigie simu kwa 1-877-687-6651 (TTY: 1-800-662-1220).</p>