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 1-800-657-8205 or go to www.uhone.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 https://www.healthcare.gov/sbc-glossary or call 1-800-657-8205 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,500/Individual or $5,000/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. Children's dental check-ups, preventive care, and outpatient prescription drugs 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 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?	$8,550 individual / $17,100 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 limit 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.uhone.com or call 1-800-657-8205 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	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only

Important Questions	Answers	Why This Matters:
see a specialist?		if you have a referral before you see the specialist.

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	30% coinsurance	Not covered	None
	Specialist visit	30% coinsurance	Not covered	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	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 (blood work)	30% coinsurance (Doctor's Office/ Freestanding Facility) 50% coinsurance (Hospital-Based Lab)	Not covered	None
	X-ray	30% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance (Doctor's Office/ Freestanding Facility) 50% coinsurance (Hospital-Based)	Not covered	You must obtain pre-approval for complex imaging services or benefits will be reduced by 50%.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.uhone.com/rx-drugs/oxford	Generic drugs (Tier 1)	$25 copay/prescription; deductible does not apply	Not covered	Limited to 30-day supply per prescription. Maximum payable by you is $150 per prescription per month. Some contraceptives may be payable under preventive care. If a name brand drug is purchased and a generic drug is available, you pay the difference unless the provider states "dispense as written" on the prescription. Generics may reside in any tier. Pre-approval is required for certain prescription drugs.
	Preferred brand drugs (Tier 2)	$50 copay/prescription ($25 copay generic); deductible does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	50% coinsurance; deductible does not apply	Not covered	
	Specialty drugs (Tier 4)			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance (Doctor's Office/Freestanding Facility) 50% coinsurance (Hospital-Based)	Not covered	You must obtain pre-approval for any non-emergency procedure performed outside of a practitioner's office or covered professional charges for surgery will be reduced by 50%.
	Physician/surgeon fees	30% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	30% coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	You must obtain pre-approval for any non-emergency hospital admission or benefits will be reduced by 50%.
	Physician/surgeon fees	30% coinsurance	Not covered	You must obtain pre-approval for any non-emergency procedure performed outside of a practitioner's office or covered professional charges for surgery will be reduced by 50%.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	Not covered	None
	Inpatient services	30% coinsurance	Not covered	You must obtain pre-approval for any non-emergency hospital admission or benefits will be reduced by 50%.
If you are pregnant	Office visits	No charge; deductible does not apply	Not covered	Depending on the type of services, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	You must obtain pre-approval for home health care services or benefits will be reduced by 50%.
	Rehabilitation services	30% coinsurance	Not covered	Charges for rehabilitative physical, occupational, speech and cognitive therapy services are limited to 30 visits each per covered person per calendar year. Limits do not apply to inpatient treatment. You must obtain pre-approval for extended care and rehabilitation, physical, occupational, speech and cognitive therapy services or benefits will be reduced by 50%.
	Habilitation services	30% coinsurance	Not covered	Charges for habilitative physical, occupational and speech therapy services are limited to 30 visits each per covered person per calendar year. Limit does not apply to autism and other developmental disabilities. You must obtain preapproval for physical, occupational, and speech therapy services or benefits will be reduced by 50%.
	Skilled nursing care	30% coinsurance	Not covered	You must obtain pre-approval for treatment, services and supplies for extended care and rehabilitation or benefits will be reduced by 50%.
	Durable medical equipment	30% coinsurance	Not covered	You must obtain pre-approval for durable medical equipment or benefits will be reduced by 50%.
	Hospice services	30% coinsurance	Not covered	You must obtain pre-approval for treatment, services and supplies for hospice care or benefits will be reduced by 50%.
If your child needs dental or eye care	Children's eye exam	30% coinsurance	Not covered	Limited to 1 exam in a 12 month period.
	Children's glasses	30% coinsurance	Not covered	Limited to 1 pair of standard lenses for glasses, and 1 pair of standard frames, or a 12 month supply of contact lenses in a 12 month period.
	Children's dental check-up	No charge; deductible does not apply	Not covered	Oral evaluations, cleanings, and fluoride treatments limited to 1 every 6 months.

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 traveling outside the U.S.
- Routine eye 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 – Limited to one surgical procedure within a two-year period
- Chiropractic Care – Limited to 30 visits per covered person per calendar year
- Hearing Aids (under age 16) - limited to 1 hearing aid per hearing impaired ear per 24-month period
- Infertility Treatment – You must obtain pre-approval or benefits will be reduced by 50%
- Private-Duty Nursing – Services limited to home health care only

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 or Healthcare.gov at http://www.healthcare.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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: New Jersey State Insurance Department at 1-800-446-7467.

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 1-800-657-8205.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-657-8205.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-657-8205.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-657-8205.

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	**$2,500**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$2,500
Copayments	$10
Coinsurance	$3,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,870**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,500**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$1,900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,500**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$2,500
Copayments	$10
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,600**

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