



Enhanced PPO



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.danbenefitsplus.com or call 1-800-597-2335. 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 1-800-765-6717 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> : \$750.00 Individual / \$1,500.00 Family <u>Non-Network</u> : \$3,000.00 Individual / \$6,000.00 Family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive Care</u> and primary care services with <u>copay</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network provider</u> : \$5,500.00 Individual / \$11,000.00 Family For out-of- <u>network providers</u> : \$11,000.00 Individual / \$22,000.00 Family per calendar year	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain <u>prior authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.myuhc.com or call 1-800-765-6717 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	\$30.00 copay /visit	30% coinsurance	Virtual visit – in- network no charge by a Designated Virtual Network Provider . No virtual visit coverage for out of network . If you receive services in addition to office visit, additional copays, deductibles , or coinsurance may apply.
	Specialist visit	\$50.00 copay /visit	30% coinsurance	If you receive services in addition to office visit, additional copays, deductibles , or coinsurance may apply.
	Preventive care/screening/immunization	No charge	30% 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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Prior Authorization required for Sleep Studies or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network or benefit reduces to 50% of allowed.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com	Generic Drugs (Tier 1)	Retail: \$10.00 <u>copay</u> Mail Order: \$20.00 <u>copay</u>	Retail: \$10.00 <u>copay</u>	Cost share may be waived for certain drugs and supplies; pre-authorization required for certain drugs. Certain preventive medications (including certain contraceptives) are covered at No Charge.
	Preferred brand drugs (Tier 2)	Retail: \$50.00 <u>copay</u> Mail Order: \$100.00 <u>copay</u>	Retail: \$50.00 <u>copay</u>	
	Non-preferred brand drugs (Tier 3)	Retail: \$75.00 <u>copay</u> Mail Order: \$150.00 <u>copay</u>	Retail: \$75.00 <u>copay</u>	
	<u>Specialty drugs</u> (Tier 4)	Retail: N/A Mail Order: N/A	Retail: N/A Mail Order: N/A	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$500.00 <u>copay</u> /visit	\$500.00 <u>copay</u> /visit	None
	<u>Emergency medical transportation</u>	\$250.00 <u>copay</u> /visit	\$250.00 <u>copay</u> /visit	None
	<u>Urgent care</u>	\$50.00 <u>copay</u> /visit	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30.00 <u>copay</u> /visit	30% <u>coinsurance</u>	<u>Prior Authorization</u> out of <u>network</u> required for certain services or benefit reduces to 50% of allowed. Partial <u>Hospitalization</u> /Intensive Outpatient Treatment in- <u>network</u> 10% after <u>plan deductible</u> . Intensive Behavioral Therapy (ABA) in <u>network</u> 10%, no <u>deductible</u> , out of <u>network</u> 30%, no <u>deductible</u> .
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> for inpatient facility or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	\$30.00 <u>copay</u> /initial visit only	30% <u>coinsurance</u>	<u>Prior Authorization</u> required for out-of- <u>network</u> for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or benefit reduces to 50% of allowed. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound)
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 120 visits per calendar year for <u>Home Health Care</u> . <u>Prior Authorization</u> required out-of- <u>network</u> for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN) or benefit reduces to 50% of allowed.
	<u>Rehabilitation services</u>	\$50.00 <u>copay</u> /visit	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Habilitation services</u>	Not covered	Not covered	<u>Habilitation Services</u> are not covered.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 180 days per calendar year. <u>Prior Authorization</u> required out-of-network or benefit reduces to 50% of allowed.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> required out of network for DME over \$1,000 or benefit reduces to 50% of allowed.
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network before admission for an inpatient stay in a hospice facility or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Child Routine vision exam is not covered.
	Children's glasses	Not covered	Not covered	Child Glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Child dental check-up is not covered.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)			
- Adult routine vision exam (i.e. refraction) - Cosmetic Surgery - Dental Care (Adult)	<u>Habilitation Services</u> - Long-term care - Non-emergency care when traveling outside the U.S.	- Private-duty nursing - Routine foot care - Weight loss programs	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
- Acupuncture - 60 visits per calendar year - Bariatric Surgery	- Chiropractic care - 60 visits per calendar year - Hearing aids – \$5,000 Per Calendar Year	Infertility treatment - \$50,000 Per Lifetime	

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-800-765-6717 or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 1-800-765-6717.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-765-6717.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-800-765-6717.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deitsch, ruf 1-800-765-6717 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-765-6717.

Samoa (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-765-6717.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-765-6717.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-800-765-6717.

—————*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 <u>plan's</u> overall deductible	\$750.00
■ <u>Specialist copayment</u>	\$50.00
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

Specialist office visits (*pre-natal 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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$750.00
<u>Copayments</u>	\$10.00
<u>Coinsurance</u>	\$1,200.00
<u>What isn't covered</u>	
Limits or exclusions	\$60.00
The total Peg would pay is	\$2,020.00

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall deductible	\$750.00
■ <u>Specialist copayment</u>	\$50.00
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100.00
<u>Copayments</u>	\$1,400.00
<u>Coinsurance</u>	\$0.00
<u>What isn't covered</u>	
Limits or exclusions	\$20.00
The total Joe would pay is	\$1,520.00

Mia's Simple Fracture

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

■ The <u>plan's</u> overall deductible	\$750.00
■ <u>Specialist copayment</u>	\$50.00
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400.00
<u>Copayments</u>	\$1,100.00
<u>Coinsurance</u>	\$0.00
<u>What isn't covered</u>	
Limits or exclusions	\$0.00
The total Mia would pay is	\$1,500.00