# Level 2

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Service **Coverage for:** Employee/Family| **Plan Type:** PS1

**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.teamsters251hsip.org or call 1-401-467-3323. 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.dol.gov/ebsa/healthreform or call 1-401-467-3323 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: $500 Individual / $1,000 Family<br>Non-Network: $500 Individual / $1,000 Family<br>Per calendar year.<br>Does not apply to copays, pharmacy drugs, and services listed below as "No Charge". | 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 categories with copay are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the annual 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 services at www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No, there are no other deductibles. | You don't have to meet deductibles for specific service, but see the chart starting on page 2 for other costs for services this plan covers. |
| **What is the out-of-pocket limit for this plan?** | Medical- Network: $2,000 Individual / $4,000 Family<br>Non-Network: $4,000 Individual / $8,000 Family per calendar year | 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, deductibles, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See www.myuhc.com or call 1-866-527-9596 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 | $15 Copay/visit | 30% Coinsurance | Christian Science Practitioners are not covered. |
| | Specialist visit | $25 Copay/visit | 30% Coinsurance | Christian Science Practitioners are not covered. |
| | Preventive care/screening/ immunization | No Charge | 30% Coinsurance | Includes preventive health services specified in the health care reform law. 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) | No Charge | 30% Coinsurance | Advance Notification required for Non-Network sleep studies. |
| | Imaging (CT/PET scans, MRIs) | No Charge | 30% Coinsurance | Advance Notification required Non-Network services. |

| 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.caremark.com** | Generic Drugs (Tier 1) | Retail: 20% Coinsurance deductible does not apply Mail Order: 20% Coinsurance deductible does not apply | Retail: 20% Coinsurance deductible does not apply | Out-of-pocket limit: $4,350 Individual / $8,700 Family. Prescription drugs apply to the prescription drug out-of-pocket limit. Certain preventive medications (including certain contraceptives) are covered at No Charge. Your prescription drug plan requires the use of mail order services or CVS/pharmacy for all maintenance medications, however, you may receive two (2) fills(one original fill plus one refill) at your retail pharmacy prior to being required to use mail service or CVS/pharmacy. Maximum $50 per prescription for a 30-day supply at the retail pharmacy. By using mail service or CVS/pharmacy you will be able to obtain a 90-day supply for equivalent of two (2) retail copayments. A three month prescription (90 day) supply for the price of two months. $100 maximum copayments on a (90 day) supply. |
| | Preferred brand drugs (Tier 2) | Retail: 25% Coinsurance deductible does not apply Mail Order: 25% Coinsurance deductible does not apply | Retail: 25% Coinsurance deductible does not apply | |
| | Non-preferred brand drugs (Tier 3) | Retail: 35% Coinsurance deductible does not apply Mail Order: 35% Coinsurance deductible does not apply | Retail: 35% Coinsurance deductible does not apply | |
| | Specialty drugs (Tier 4) | Available through CVS Specialty Pharmacy | Retail: Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% Coinsurance | 30% Coinsurance | None |
| | Physician/surgeon fees | 10% Coinsurance | 30% Coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $100 Copay/visit | $100 Copay/visit | None |
| | Emergency medical transportation | 10% Coinsurance deductible does not apply | 30% Coinsurance deductible does not apply | Air and water up to a $3,000 maximum per occurrence. |
| | Urgent care | $50 Copay/visit | 30% 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) | 10% Coinsurance | 30% Coinsurance | Advance Notification required for Non-Network stay. |
| | Physician/surgeon fees | 10% Coinsurance | 30% Coinsurance | Christian Science Practitioners are not covered. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $15 Copay/visit | 30% Coinsurance | None |
| | Inpatient services | 10% Coinsurance | 30% Coinsurance | Advance Notification is required for Non-Network services. Advance Notification is also required for Non-Network benefits provided for Applied Behavioral Analysis (ABA). |
| **If you are pregnant** | Office visits | $15 Copay/initial visit only | 30% Coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Advance Notification required when exceeding delivery time for Non-Network services. |
| | Childbirth/delivery professional services | 10% Coinsurance | 30% Coinsurance | |
| | Childbirth/delivery facility services | 10% Coinsurance | 30% Coinsurance | |
| **If you need help recovering or have** | Home health care | 10% Coinsurance | 30% Coinsurance | Advance Notification required for Non-Network home healthcare, private duty nursing and nutrition. |

| 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) | |
| **other special health needs** | Rehabilitation services | Physical, Occupational, Speech, and Post-Cochlear Implant Aural Therapies: 0% Coinsurance<br>Cardiac Rehabilitation: 10% Coinsurance<br>Pulmonary Rehabilitation: No Charge | 30% Coinsurance | Review after 30 visits for Physical Therapy, Occupational Therapy, and Speech Therapy. No limits for Pulmonary Rehabilitation or Post-Cochlear Implant Aural Therapy. Cardiac Rehabilitation limited to 36 visits per calendar year. |
| | Habilitation services | Not Covered | Not Covered | None |
| | Skilled nursing care | 10% Coinsurance | 30% Coinsurance | Advance Notification required for Non-Network skilled nursing, private duty nursing, nutrition. |
| | Durable medical equipment | 10% Coinsurance | 30% Coinsurance | Advance Notification required for DME devices that cost more than $1000 per device. |
| | Hospice services | 10% Coinsurance | 30% Coinsurance | Advance Notification required for Non-Network inpatient stay. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | None |
| | Children's glasses | Not Covered | Not Covered | Not Covered |
| | Children's dental check-up | No Charge | Plan pays Network provider's allowed amount | Network coverage at a Delta Dental provider. One oral exam per calendar year. Dental benefits are administrated separately from the medical benefits. |

## 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
- Adult routine vision exam (i.e. refraction)
- Child routine vision exam (i.e. refraction
- Child vision glasses
- Cosmetic Surgery
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Child dental check-up
- Chiropractic care
- Dental Care (Adult)
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Routine foot care

**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 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 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: 1-401-467-3323 or visit www.teamsters251hsip.org or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.
Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at. http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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

**Does this plan meet the Minimum Value Standards? Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-401-467-3323.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-401-467-3323.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-401-467-3323.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-401-467-3323.

*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** | **$500** |
| ■ **Specialist copayment** | **$25** |
| ■ **Hospital (facility) coinsurance** | **10%** |
| ■ **Other coinsurance** | **10%** |

**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** | **$12,800** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $30 |
| Coinsurance | $1,140 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,730** |

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

| | |
|---|---|
| ■ **The plan's overall deductible** | **$500** |
| ■ **Specialist copayment** | **$25** |
| ■ **Hospital (facility) coinsurance** | **10%** |
| ■ **Other coinsurance** | **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** | **$7,400** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $170 |
| Coinsurance | $1,380 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,610** |

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

| | |
|---|---|
| ■ **The plan's overall deductible** | **$500** |
| ■ **Specialist copayment** | **$25** |
| ■ **Hospital (facility) coinsurance** | **10%** |
| ■ **Other coinsurance** | **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** | **$1,900** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $80 |
| Coinsurance | $80 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$660** |



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

Grandfathered Health Plan Notice

This Plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("the Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (401)-467-3323. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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

If you think you were treated unfairly 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, UTAH 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 number listed within this Summary of Benefits and Coverage (SBC), 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, 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 other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.



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

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

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 ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 **(Korean)** 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage, SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

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 nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION: Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage, SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer 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。
本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリー
ダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री 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 dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ **(Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការគ្របដណ្តប់ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

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 Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' 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 bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).