




EPO HSA 4000 / 8000



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 [BenefitsatAllFire.com](https://www.benefitsatallfire.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.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> : \$4,000 Individual / \$8,000 Family <u>Out-of-Network</u> : Not Covered 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive Care</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> ?	<u>Network provider</u> : \$6,500 Individual / \$13,000 Family per calendar year. <u>Out-of-network providers</u> : Not Covered	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.	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 <u>network provider</u> ?	Yes. See www.myuhc.com for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	30% <u>coinsurance</u>	Not covered	Virtual visit - In- <u>network</u> 30% <u>coinsurance</u> after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . No virtual visit coverage for out-of- <u>network</u> . If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or co-ins may apply.
	<u>Specialist</u> visit	30% <u>coinsurance</u>	Not covered	If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or <u>coinsurance</u> may apply.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	Not covered	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 drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.optumrx.com	Tier 1 – Usually Your Lowest Cost Option, Mostly Generics	Retail: 10% coinsurance with a \$15 copay maximum. Retail-90 / Mail Order: 10% coinsurance with a \$35 copay maximum	Not Covered	Provider means pharmacy for purposes of this section. If available/not prohibited in your state: Retail: Up to a 31 day supply. Retail-90/Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain prescription drugs may require pre-authorization before coverage will be provided. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. 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. Prescription drug costs are subject to the annual deductible.
	Tier 2 – Usually Your Mid-Range Cost Option, Mostly Preferred Brands	Retail: 10% coinsurance with a \$40 copay maximum. Retail-90 / Mail Order: 10% coinsurance with a \$100 copay maximum	Not Covered	
	Tier 3 – Usually Your Highest Cost Option, Mostly Non-Preferred Brands	Retail: 10% coinsurance with a \$75 copay maximum. Retail -90 / Mail Order: 10% coinsurance with a \$185 copay maximum	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	None
	<u>Emergency room care</u>	30% <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 immediate medical attention	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Urgent care</u>	30% <u>coinsurance</u>	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u>	Not covered	None
	Inpatient services	30% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	30% <u>coinsurance</u>	Not covered	<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	30% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	Not covered	Limited to 60 visits per calendar year for <u>Home Health Care</u> .
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	Not covered	Limited to 36 visits per calendar year for Cardiac Rehabilitation. Limited to 20 visits each per calendar year for Pulmonary and Cognitive Therapies. Limited to 60 visits per calendar each Occupational, Physical, & Speech Therapy. Visit Limits do not apply to members with autism spectrum disorder diagnosis.

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>	30% <u>coinsurance</u>	Not covered	<u>Habilitation Services</u> are provided, and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	Not covered	Limited to 60 days per calendar year.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	Not covered	None
	<u>Hospice services</u>	30% <u>coinsurance</u>	Not covered	None
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> .)		
<ul style="list-style-type: none"> Acupuncture Adult routine vision exam (i.e. refraction) Cosmetic Surgery 	<ul style="list-style-type: none"> Dental Care (Adult) Infertility treatment Long-term care 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Private-duty nursing Routine foot care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> Bariatric Surgery Chiropractic care 	<ul style="list-style-type: none"> Hearing aids 	<ul style="list-style-type: none"> Weight loss programs

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, 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? No

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 <u>plan's</u> overall deductible	\$4,000
■ <u>Specialist coinsurance</u>	30%
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$4,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,500
<u>What isn't covered</u>	
Limits or exclusions	\$70
The total Peg would pay is	\$6,570

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	\$4,000
■ <u>Specialist coinsurance</u>	30%
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,100
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$4,300
The total Joe would pay is	\$5,400

Mia's Simple Fracture

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

■ The <u>plan's</u> overall deductible	\$4,000
■ <u>Specialist coinsurance</u>	30%
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$10
The total Mia would pay is	\$2,810