Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage Period:**

Name of Trust ERISA Plan: Excelsior Higher Care HD **Plan Type: ERISA**

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 866-549- 4199. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Coordinated Care (UCR) Individual $5,000 / Family $11,000 Coordinated Care PHCS/MultiPlan Individual $7,000 / Family $14,000 Care not Coordinated Individual $7,000 / Family $14,000	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. Some services required by the ACA are not subject to the deductible.
Are there services without having Copayments?	Yes. Preventive care and primary care services are covered when using your in network provider.	Copayments or coinsurance apply to this plan. However, some services do not require a Copayment when using in-network physicians. For example, this plan covers certain preventive services. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other Copay's for specific services?	Yes. failure to pre-certify Inpatient admission, Dialysis, admission to Extended Care Facility or Physical Therapy. Can result in the Participant being charged the maximum OOP or having coverage denied.	Preauthorization is required for Inpatient Hospital admissions, Dialysis, admission to Extended Care Facility or Physical Therapy or an additional Maximum OOP copay could be applied before the Plan benefits are determined, which could include denial of coverage.
What is the out-of- pocket limit for this plan?	Coordinated Care (UCR) Individual $7,900 / Family $15,000 Coordinated Care PHCS/MultiPlan Individual $9,900 / Family $17,000 Care not Coordinated Individual $9,900 / Family $17,000	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?	Copayments for certain services, 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 Primary Network provider?	Yes. By using the providers identified with your employer Network you can reduce your overall medical costs and have more predictable expenses.	This plan uses a providers that are coordinated and directly contracted. You will pay less if you use a provider that is Coordinated or has a Direct Contract. You will pay the most if you use a non-coordinated 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 coordinated or contracted provider might use an non-coordinated 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 don't need a referral to see an in-network specialist. (primary network only)	You can see the in-network **specialist** without permission from this plan.

This Plan has a Deductible, Co-Insurance and Copayments identified in the plan which are the members responsibility.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Excelsior HD Care Coordinated (UCR)	Excelsior HD Coordinated Care PHCS/MultiPlan	Excelsior HD Care not Coordinated	
If you visit a health care provider's office or clinic	Primary care Office Visit	**$0 Copay**	**$50 Copay**	**After deductible is met $50 Copay**	Copay applies to Office Visit Only.
	Specialist Office Visit	**$0 Copay**	**$75 Copay**	**After deductible is met $75 Copay**	
	Preventive care/screening/ immunization	**$0 Copay**	**$0 Copay**	**$0 Copay**	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (blood work)	**$0 Copay**	**After deductible is met $50 Copay**	**After deductible is met $50 Copay**	None
	Imaging (X-ray, CT/PET scans, MRIs, Ultrasound)	**$0 Copay**	**After deductible is met $250 Copay**	**After deductible is met $250 Copay**	

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If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://drexi.com/welcome	Generic drugs	**All RX Pricing is noted below, and Copays are based on the RX over the counter price.**			Formulary available upon request
	Preferred brand drugs	**After Deductible is met** **Tier — Copay** **Tier 1 — $5** **Tier 2 — $10** **Tier 3 — $20** **Tier 4 — $50** **Tier 5 — 50% Coinsurance**			Covers up to a 90-day supply (retail prescription)
	Non-preferred brand drugs	**For RX over $600.00 request Patient Advocacy support to fill medical RX needs.** **The plan does not restrict RX by brand or Generic**			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**After deductible is met $400 Copay**	**After deductible is met $400 Copay**	**After deductible is met $400 Copay**	None
	Physician/surgeon fees	**After deductible is met $25 Copay**	**After deductible is met $25 Copay**	**After deductible is met $25 Copay**	None
If you need immediate medical attention	Emergency room care Free Standing ER	**After deductible is met $500 Copay** **Excluded**	**After deductible is met $500 Copay** **Excluded**	**After deductible is met $500 Copay** **Excluded**	Copay only applies to other In Network and Out of Network if TRUE Emergency Free standing ER excluded
	Emergency medical transportation	**After deductible is met $250 Copay**	**After deductible is met $250 Copay**	**After deductible is met $250 Copay**	
	Urgent care	**After deductible is met $75 Copay**	**After deductible is met $75 Copay**	**After deductible is met $75 Copay**	
If you have a hospital stay	Facility fee (e.g., hospital room)	**After deductible is met $500 Copay Daily**	**After deductible is met $500 Copay Daily**	**After deductible is met $500 Copay Daily**	Must have Preauthorization call 1- 866-549-4199.
	Physician/surgeon fees	**After deductible is met $25 Copay**	**After deductible is met $25 Copay**	**After deductible is met $25 Copay**	Per documented encounter

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If you need mental health, behavioral health, or substance abuse services	Outpatient services	**$0 Copay**	**After deductible is met $75 Copay**	**After deductible is met $75 Copay**	Services must be pre-certified at 1-866-549-4199
	Inpatient services	**After deductible is met Copays of $500 Daily**	**After deductible is met Copays of $500 Daily**	**After deductible is met Copays of $500 Daily**	Services must be pre-certified at 866-549- 4199
If you are pregnant	Office visits	**$25 Copay**	**After deductible is met $50 Copay**	**After deductible is met $50 Copay**	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).
	Childbirth/delivery professional services	**$25 Copay**	**After deductible is met $50 Copay**	**After deductible is met $50 Copay**	
	Childbirth/delivery facility services	**After deductible is met $500 Copay Daily**	**After deductible is met $500 Copay Daily**	**After deductible is met $500 Copay Daily**	Services must have Preauthorization at 866-549-4199 for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.
If you need help recovering or have other special health needs	Home health care	**After deductible is met $50 Copay Daily**	**After deductible is met $50 Copay Daily**	**After deductible is met $50 Copay Daily**	Services must be pre-certified at 866-549- 4199
	Rehabilitation services Outpatient	**After deductible is met $50 Copay Daily**	**After deductible is met $50 Copay Daily**	**After deductible is met $50 Copay Daily**	Inpatient services or outpatient Physical Therapy must have Preauthorization at 866-549-4199
	Habilitation services	**After deductible is met $50 Copay Daily**	**After deductible is met $50 Copay Daily**	**After deductible is met $50 Copay Daily**	Services must be pre-certified at 866-549- 4199
	Skilled nursing care	**After deductible is met $25 copay Daily**	**After deductible is met $25 copay Daily**	**After deductible is met $25 copay Daily**	Must have Preauthorization at 866- 549-4199
	Durable medical equipment	**After deductible tiered Copay: $50 Copay for price up to $200.00** **$100.00 copay for price $201.00-$500.00** **20% copay for price $501.00 and up** **Does not go towards DED/OOP.**	**After deductible tiered Copay: $50 Copay for price up to $200.00** **$100.00 copay for price $201.00-$500.00** **20% copay for price $501.00 and up** **Does not go towards DED/OOP.**	**After deductible tiered Copay: $50 Copay for price up to $200.00** **$100.00 copay for price $201.00-$500.00** **20% copay for price $501.00 and up** **Does not go towards DED/OOP.**	Must be pre-certified at 866-549-4199 Disposable Parts Excluded 90 day rental required for CPAP/BiPap/Hospital Beds prior to purchase. Rental copay may apply.

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	Hospice services	**After deductible is met $75 Copay Daily**	**After deductible is met $75 Copay Daily**	**After deductible is met $75 Copay Daily**	Services must have Preauthorization at 866-549-4199
If your child needs dental or eye care	Children's eye exam	As defined under Preventive	As defined under Preventive	As defined under Preventive	Only as defined under Preventive
	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Bariatric surgery
- Hearing aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Private-duty nursing
- Weight loss programs
- Allergy Treatments

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
N/A	N/A	N/A

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 plan at **866-549-4199.** You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 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 866-219-1592.
[Tagalog (Tagalog): Kung kailanganninyoangtulong sa Tagalog
tumawag sa 866-219-1592. [Chinese (中文): 如果需要中文的帮
助，请拨打这个号码866-219-1592.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-219-1592.