

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) \$0 Deductible	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 .
	Coordinated Care PHCS/MultiPlan Individual \$4,000 Family \$11,000	
	Care not Coordinated Individual \$4,000 Family \$11,000	
Are there services without having Copayments?	Yes. Preventive care and primary care services are covered when using your Coordinated/Direct Contract Care provider.	Copayments or coinsurance apply to this plan. However, some services do not require a Copayment when using Coordinated or Contracted 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 \$6,350 / Family \$12,500	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.
	Coordinated Care PHCS/MultiPlan Individual \$7,350 / Family \$15,500	
	Care not Coordinated Individual \$7,350 / Family \$15,500	
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 Coordinated or direct contracted Primary provider?	Yes. By using the providers identified with your employer 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 coordinated or direct contracted specialist.	You can see the coordinated or contracted specialist you choose without permission from this plan.



This plan has Non-Coordinated deductible. [Copayments](#) identified in the plan are the members responsibility.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Excelsior Platinum Care Coordinated (UCR)	Excelsior Platinum Coordinated Care PHCS/MultiPlan	Excelsior Platinum Care not Coordinated	
If you visit a health care provider's office or clinic	Primary care office visit	\$0 Copay	\$30 Copay	After Deductible \$30 copay	Copay applies to Office Visit Only.
	Specialist office visit	\$0 Copay	\$50 Copay	After Deductible \$50 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 \$50 Copay	After Deductible \$50 Copay	None
	Imaging (X-ray, CT/PET scans, MRIs, Ultrasound)	\$0 Copay	After Deductible \$250 Copay	After Deductible \$250 Copay	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information												
		Excelsior Platinum Care Coordinated (UCR)	Excelsior Platinum Coordinated Care PHCS/MultiPlan	Excelsior Platinum Care not Coordinated													
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://drex.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 Covers up to a 90-day supply (retail prescription)												
	Preferred brand drugs	<table><tr><td>Tier</td><td>Copay</td></tr><tr><td>1</td><td>\$5</td></tr><tr><td>2</td><td>\$10</td></tr><tr><td>3</td><td>\$20</td></tr><tr><td>4</td><td>\$50</td></tr><tr><td>5</td><td>50% Coinsurance</td></tr></table>				Tier	Copay	1	\$5	2	\$10	3	\$20	4	\$50	5	50% Coinsurance
	Tier	Copay															
	1	\$5															
	2	\$10															
3	\$20																
4	\$50																
5	50% Coinsurance																
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)	\$400 Copay	After Deductible \$400 Copay	After Deductible \$400 Copay	None												
	Physician/surgeon fees	\$25 Copay	After Deductible \$25 Copay	After Deductible \$25 Copay	None												
If you need immediate medical attention	Emergency room care	\$500 Copay	After Deductible \$500 Copay	After Deductible \$500 Copay	Copay only applies to other In-network and out- of-network if TRUE Emergency												
	Free standing ER	Excluded	Excluded	Excluded													
	Emergency medical transportation	\$250 Copay	After Deductible \$250 Copay	After Deductible \$250 Copay													
	Urgent care	\$75 Copay	After Deductible \$75 Copay	After Deductible \$75 Copay	Freestanding ER excluded												
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 Copay Daily	After Deductible \$500 Copay Daily	After Deductible \$500 Copay Daily	Must have Prior Authorization call 866-549-4199.												
	Physician/surgeon fees	\$25 Copay	After Deductible \$25 Copay	After Deductible \$25 Copay	Per documented encounter												

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Excelsior Platinum Care Coordinated (UCR)	Excelsior Platinum Coordinated Care PHCS/MultiPlan	Excelsior Platinum Care not Coordinated	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 Copay	After Deductible \$25 Copay	After Deductible \$25 Copay	Services must be pre-certified at 866- 549-4199
	Inpatient services	\$500 Copay daily	After Deductible \$500 Copay daily	After Deductible \$500 Copay daily	Services must be pre-certified at 866-549-4199
If you are pregnant	Office visits	\$0 Copay	After Deductible \$25 copay	After Deductible \$25 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	\$0 Copay	After Deductible \$25 Copay	After Deductible \$25 Copay	
	Childbirth/delivery facility services	\$0 Copay	After Deductible \$500 Copay - Daily	After Deductible \$500 Copay - Daily	Services must have Preauthorization at 1-866-549-4199 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	\$50 Copay Daily	After Deductible \$50 Copay Daily	After Deductible \$50 Copay Daily	Services must be pre-certified at 866-549-4199. Limited to 2 hours per day up to 25 days per Calendar Year
	Rehabilitation services Outpatient	\$50 Copay Daily	After Deductible \$50 Copay Daily	After Deductible \$50 Copay Daily	Inpatient services or outpatient Physical Therapy must have Preauthorization at 866-549-4199 Limited to Combined 50 visits per year.
	Habilitation services	\$50 Copay Daily	After Deductible \$50 Copay Daily	After Deductible \$50 Copay Daily	Services must be pre-certified at 866-549-4199. Limited to Combined 50 visits per year.
	Skilled nursing care	\$50 Copay Daily	After Deductible \$50 Copay Daily	After Deductible \$50 Copay Daily	Must have Preauthorization at 866-549-4199. Limited to 20 days.
	Durable medical equipment	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	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	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	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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Excelsior Platinum Care Coordinated (UCR)	Excelsior Platinum Coordinated Care PHCS/MultiPlan	Excelsior Platinum Care not Coordinated	
	Hospice services	\$75 Copay Daily	After Deductible \$75 Copay Daily	After Deductible \$75 Copay Daily	Inpatient services must have Preauthorization at 866-549-4199. Limited to 30 days.
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:

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

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> • Cosmetic Surgery • Dental Care • Infertility Treatment • Bariatric surgery • Hearing aids | <ul style="list-style-type: none"> • Long Term Care • Non-emergency care when traveling outside the U.S. • Private Duty Nursing | <ul style="list-style-type: none"> • 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): Kungkailangan ninyoangtulong sa Tagalog tumawagsa 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, kwijjigo holne' 866-219-1592.