



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <https://liteblue.usps.gov> or by calling 1-877-477-3273 # 5.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	Network: \$1,500 Individual / \$3,000 Family Non-Network: Not Covered / Per calendar year. Does not apply to copays, pharmacy drugs, and services listed below as “No Charge”.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
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.
Is there an out-of-pocket limit on my expenses?	Medical- Network: \$5,000 Individual / \$10,000 Family Non-Network: Not Covered	The out-of-pocket limit is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums , balanced-billed charges, health care this plan doesn’t cover.	Even though you pay these expenses, they don’t count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers ?	Yes, this plan uses network providers . If you use a non-network provider your cost may be more. For a list of network providers , see www.welcometouhc.com or call 1-888-496-6959.	If you use a network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn’t cover?	Yes	Some of the services this plan doesn’t cover are listed on Page 4. See your policy or plan document for additional information about excluded services .

Questions: Call 1-888-496-6959 or visit us at www.welcometouhc.com. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call the number above to request a copy.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Employee/Family | Plan Type: EP1

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Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan only covers services if rendered by network **providers**. Exceptions include emergency services as described in your policy.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 Copay/visit	Not Covered	Virtual visit- in network \$30 copay per visit by a Designated Virtual Network Provider. No virtual coverage out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	\$60 Copay/visit	Not Covered	None
	Other practitioner office visit	\$60 Copay/visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Care. 20 visits per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance After Deductible	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance After Deductible	Not Covered	None

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If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com .	Tier 1 - Your Lowest-Cost Option	Retail: \$10 Copay Mail Order: \$25 Copay	Retail: Not Covered	Tier 1 Contraceptives covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: 30% Coinsurance Mail Order: 30% Coinsurance	Retail: Not Covered	30% coinsurance; max \$250 retail / \$500 mail order
	Tier 3 - Your Highest-Cost Option	Retail: 30% Coinsurance Mail Order: 30% Coinsurance	Retail: Not Covered	30% coinsurance; max \$250 retail; \$500 mail order
	Tier 4 - Additional High-Cost Option	Retail: N/A Mail Order: N/A	Retail: N/A	Retail: up to 31 day supply. Mail order: up to 90 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance After Deductible	Not Covered	None
	Physician/surgeon fees	30% Coinsurance After Deductible	Not Covered	None
If you need immediate medical attention	Emergency room services	\$300 Copay/visit	\$300 Copay/visit	Coinsurance for Non-Emergency health services is 50%.
	Emergency medical transportation	30% Coinsurance After Deductible	30% Coinsurance After Deductible	Prior authorization required for non-emergency ambulance.
	Urgent care	\$75 Copay/visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 Copay/visit	Not Covered	\$500 copay per day for days 1-3 of each admission.
	Physician/surgeon fee	30% Coinsurance After Deductible	Not Covered	None

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$30 Copay/visit	Not Covered	EAP- Magellan Health Services 1-800-327-4968
	Mental/Behavioral health inpatient services	\$500 Copay/visit	Not Covered	\$500 copay per day for days 1-3 of each admission.
	Substance use disorder outpatient services	\$30 Copay/visit	Not Covered	EAP- Magellan Health Services 1-800-327-4968
	Substance use disorder inpatient services	\$500 Copay/visit	Not Covered	\$500 copay per day for days 1-3 of each admission.
If you are pregnant	Prenatal and postnatal care	30% Coinsurance After Deductible	Not Covered	Routine pre-natal care is covered at no charge. Your cost in this category includes physician delivery charges.
	Delivery and all inpatient services	\$500 Copay/visit	Not Covered	\$500 copay per day for days 1-3 of each inpatient hospital admission. Your cost for inpatient services only. For physician delivery charges, see pre/post natal care.

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Coverage for: Employee/Family | Plan Type: EP1

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% Coinsurance After Deductible	Not Covered	None
	Rehabilitation services	\$60 Copay/visit	Not Covered	60 visits each per calendar year for occupational, physical and speech therapy. Cardiac and pulmonary rehabilitation unlimited visits.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	30% Coinsurance After Deductible	Not Covered	60 days per calendar year
	Durable medical equipment	30% Coinsurance After Deductible	Not Covered	None
	Hospice service	30% Coinsurance After Deductible	Not Covered	None
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	30% Coinsurance After Deductible	Not Covered	For amblyopia (lazy eye) and strabismus (cross-eye) through age 18
	Dental check-up	No Charge	No Charge	Preventive care covered at no charge. 2 cleanings per year. Fluoride treatments up to age 16.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Adult routine vision exam (i.e. refraction) Bariatric Surgery Child routine vision exam (i.e. refraction) Cosmetic Surgery 	<ul style="list-style-type: none"> Habilitation services Infertility treatment Long-term care 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S Private-duty nursing Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> Acupuncture limitations may apply Chiropractic care limitations may apply 	<ul style="list-style-type: none"> Dental Care (Adult) Hearing aids limitations may apply 	<ul style="list-style-type: none"> Routine foot care limitations may apply

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-0048. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us at 1-888-496-6959 or visit www.welcometouhc.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-888-496-6959.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-496-6959.
- Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-496-6959.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-496-6959.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*-----

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,480
- Patient pays \$3,060

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,500
Copays	\$1,020
Coinsurance	\$390
Limits or exclusions	\$150
Total	\$3,060

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,470
- Patient pays \$1,930

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,150
Copays	\$700
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$1,930

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example Show

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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