




Out of Area PPO Plan with Health Reimbursement Account (OOA HRA Plan)



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.t-mobilebenefits.com or call 877-259-1527. 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 or call 877-259-1527 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network</u> : \$2,250 Individual / \$4,500 Family <u>Non-Network</u> : \$2,250 Individual / \$4,500 Family 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive Care</u> and primary care services 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>?	For <u>network provider</u> : \$4,250 Individual / \$8,500 Family For <u>out-of-network providers</u> : \$4,250 Individual / \$8,500 Family per calendar year	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, penalties for failure to obtain <u>prior authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .
Will you pay less if you use a <u>network provider</u>?	Not Applicable	This <u>plan</u> does not use a <u>provider network</u> . You can receive covered services from any <u>provider</u> .

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	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 office</u> or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Virtual visit - In <u>network</u> zero <u>co-insurance</u> by a Designated Virtual <u>Network Provider</u> . If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or <u>co-insurance</u> may apply. No virtual visit coverage for out of <u>network</u> .
	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	No charge	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)	20% <u>coinsurance</u> <u>deductible</u> does not apply	20% <u>coinsurance</u> <u>deductible</u> does not apply	<u>Prior Authorization</u> required for sleep studies.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> <u>deductible</u> does not apply	20% <u>coinsurance</u> <u>deductible</u> does not apply	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.cvs.com	Generic Drugs (Tier 1)	Retail: 10% <u>coinsurance deductible</u> does not apply Mail Order: 10% <u>coinsurance deductible</u> does not apply	Not covered	Retail (\$5 <u>copay</u> min - \$20 <u>copay</u> max) Mail (\$10 <u>copay</u> min - \$40 <u>copay</u> max)
	Preferred brand drugs (Tier 2)	Retail: 20% <u>coinsurance deductible</u> does not apply Mail Order: 20% <u>coinsurance deductible</u> does not apply	Not covered	Retail (\$25 <u>copay</u> min - \$55 <u>copay</u> max) Mail (\$50 <u>copay</u> min - \$110 <u>copay</u> max) Weight Loss Medications (anti-obesity and anorexiant) \$55 copay max.
	Non-preferred brand drugs (Tier 3)	Retail: 30% <u>coinsurance deductible</u> does not apply Mail Order: 30% <u>coinsurance deductible</u> does not apply	Not covered	Retail (\$45 <u>copay</u> min - \$80 <u>copay</u> max) Mail (\$90 <u>copay</u> min - \$160 <u>copay</u> max)
	<u>Specialty drugs</u> (Tier 4)	30% Coinsurance*	Not Covered	Please call CVS customer care at 844-757-0417 for more information on what is covered. To get started with CVS specialty call 800-237-2767. Limited to a 30-day supply. *For more information on PrudentRx and to learn if you are eligible for a \$0 copay please review the SPD or call CVS specialty to learn more.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	No charge	No charge	None

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)	
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required for certain treatments, partial <u>hospitalization</u> /intensive outpatient treatment and Intensive Behavioral Therapy (ABA).
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required for inpatient facility.
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean. <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	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u> except <u>deductible</u> doesn't apply to newborn hospital expenses when discharged with the mother	20% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 120 visits per calendar year for <u>Home Health Care</u> . <u>Prior Authorization</u> required out-of-network for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN).

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>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Occupational/Physical 75 visits combined maximum per calendar year. Speech 75 visits per calendar year. Combined maximum of 120 visits per calendar year for speech, physical and occupational therapy for congenital anomalies, developmental delay, cerebral palsy and hearing impairment. Visit limits do not apply to members with a behavioral diagnosis.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Habilitation Services</u> are provided, and limits are combined with <u>Rehabilitation Services</u> above. No visit limit for autism.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 60 days per calendar year. 120 day limit for Inpatient Rehab per calendar year. <u>Prior Authorization</u> required
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 1 durable medical equipment for same/similar purpose
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required before admission for an inpatient stay in a hospice facility.
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 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">• Adult routine vision exam (i.e. refraction)• Cosmetic Surgery | <ul style="list-style-type: none">• Dental Care (Adult)• Long-term care | <ul style="list-style-type: none">• Routine foot care• Weight loss programs |
|--|--|--|

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

- | | | |
|---|---|---|
| <ul style="list-style-type: none">• Acupuncture – Limited to 30 visits per calendar year.• Bariatric Surgery• Chiropractic care – Limited to 30 visits per calendar year. | <ul style="list-style-type: none">• Hearing aids – Limited to 1 per ear every 3 calendar years.• Infertility treatment | <ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Private-duty nursing |
|---|---|---|

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, contact: 877-259-1527 or 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? 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 877-259-1527.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 877-259-1527.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 877-259-1527.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 877-259-1527 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-259-1527.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 877-259-1527.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 877-259-1527.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 877-259-1527.

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)

■ <u>The plan's overall deductible</u>	\$2,250
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

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
---------------------------	-----------------

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,250
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,000
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,310

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ <u>The plan's overall deductible</u>	\$2,250
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

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
---------------------------	----------------

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$2,250
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

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
---------------------------	----------------

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$20
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,720