




Local 2110 Choice In-Network 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 <https://humanresources.columbia.edu> or call 1-212-851-7000. 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 1-212-851-7000 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network</u> : \$400 Individual per calendar year <u>Out-of-Network</u> : Not Covered	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 with <u>copay</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>?	For <u>Network provider</u> : \$3,500 Individual / \$7,000 Family per calendar year For <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.whyuhc.com/columbia or www.myuhc.com or call 1-800-232-9357 for a list of <u>network providers</u> . There is no coverage for Out-of- <u>Network</u> providers, except as outlined in the Common Medical Events chart.	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>copay</u> /visit	Not covered	UHC Virtual visit - In <u>network</u> \$30 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> . If you receive services in addition to office visit, additional copays, <u>deductibles</u> or <u>coinsurance</u> may apply. Other Telehealth <u>providers</u> are covered in <u>network</u> at applicable <u>copay</u> , <u>deductible</u> and <u>coinsurance</u> .
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit	Not covered	If you receive services in addition to office visit, additional copays, <u>deductibles</u> or <u>coinsurance</u> may apply. Other Telehealth <u>providers</u> are covered in <u>network</u> at applicable <u>copay</u> , <u>deductible</u> and <u>coinsurance</u> .

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>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. Age and frequency schedules may apply.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	\$150 <u>copay</u> applies to outpatient hospital facility. No <u>copay</u> for NYP/Columbia or NYP/Weill Cornell Medical Centers.
	Imaging (CT/PET scans, MRIs)	\$150 <u>copay</u> /test	Not covered	\$150 <u>copay</u> applies to outpatient hospital facility. No <u>copay</u> for NYP/Columbia or NYP/Weill Cornell Medical Centers.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com	Tier 1 – Lower cost Generic and some brand name Drugs	Retail: \$10 <u>copay</u> Mail Order: \$15 <u>copay</u>	Retail: Not covered	30 day supply retail; 90 day supply mail order. Certain preventive medications (including contraceptives) are covered at No Charge.
	Tier II – Mid range cost Preferred brand name Drugs	Retail: \$25 <u>copay</u> Mail Order: \$50 <u>copay</u>	Retail: Not covered	30 day supply retail; 90 day supply mail order
	Tier III – Higher cost Brand name and some generics	Retail: \$45 <u>copay</u> Mail Order: \$90 <u>copay</u>	Retail: Not covered	30 day supply retail; 90 day supply mail order
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <u>copay</u> /visit	Not covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not covered	None
	<u>Emergency room care</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	Emergency room <u>copay</u> waived if admitted.

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>	No charge	No charge	Non-Emergency ground and air transportation provided by a licensed professional ambulance is covered as UHC determines appropriate. <u>Prior authorization</u> required for non-emergency air ambulance or benefit will not be covered.
	<u>Urgent care</u>	\$30 <u>copay</u> /visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /visit	Not covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay</u> /visit	Not covered	Employee Assistance Program (EAP) up to 6 sessions per subject covered at No Charge. Partial <u>hospitalization</u> /intensive outpatient treatment and Intensive Behavioral Therapy (ABA): No Charge.
	Inpatient services	\$500 <u>copay</u> /visit	Not covered	None
If you are pregnant	Office visits	\$30 <u>copay</u> /initial visit only	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	0% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	\$500 <u>copay</u> /visit	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	Not covered	<u>Home health care</u> 200 visits per calendar year. Outpatient private duty nursing \$5,000 per calendar year. One visit equals four hours of Skilled Care services.

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>Rehabilitation services</u>	\$30 <u>copay</u> /visit	Not covered	Physical, Occupational combined 60 visits per calendar year. Cardiac, Cognitive, Pulmonary, Speech 60 visits each per calendar year.
	<u>Habilitation services</u>	Not covered	Not covered	<u>Habilitation Services</u> are not covered.
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	Not covered	Limit 120 days per calendar year.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	Not covered	In Office: 100% in- <u>network</u> .
	<u>Hospice services</u>	0% <u>coinsurance</u>	Not covered	Limit 6 months per lifetime.
If your child needs dental or eye care	Children's eye exam	\$10 <u>copay</u> /visit	Not covered	Child under 19: Exam 100% after \$10 <u>copay</u> . Limit 1 exam per 12 months.
	Children's glasses	No charge	Not covered	Child under 19: Lenses or 1 pair/box contacts 100%. Frames up to \$100 at 100%, 60% thereafter. Limit 1 per 12 months.
	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"> • Cosmetic Surgery • Dental Care (Adult) • <u>Habilitation Services</u> 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. 	<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 <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture 20 visits/calendar year • Adult routine vision exam (i.e. refraction) • Bariatric Surgery 	<ul style="list-style-type: none"> • Chiropractic care 60 visits/calendar year • Hearing aids 	<ul style="list-style-type: none"> • Infertility treatment \$30,000/Lifetime • 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: 1-800-232-9357 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 1-212-851-7000.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-212-851-7000.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-212-851-7000.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deitsch, ruf 1-212-851-7000 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-212-851-7000.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-212-851-7000.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-212-851-7000.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-212-851-7000.

—————*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 <u>deductible</u>	\$400
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>copayment</u>	\$500
■ Other <u>coinsurance</u>	0%

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>	\$400
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$960

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>copayment</u>	\$500
■ Other <u>coinsurance</u>	0%

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>	\$0
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>copayment</u>	\$500
■ Other <u>coinsurance</u>	0%

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>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$400