POS Schedule of Benefits

Coverage for: Single/Family| **Plan Type:** POS

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In Network: **$250** Single/**$500** Family per Benefit Year Out of Network: **$500** Single/**$1,000** Family per Benefit Year	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.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In Network: **$750** Single/**$1,500** Family per Benefit Year for medical expenses. **$2,000** Single/**$4,000** Family per Benefit Year for prescription expenses. Out of Network: **$1,500** Single/**$3,000** Family per Benefit Year for medical expenses. **$2,000** Single/**$4,000** Family per Benefit Year for prescription expenses.	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 Usual, Customary & Reasonable (UCR)?	The amount paid for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service. The UCR amount is sometimes used to determine the allowed amount.	You may be responsible for paying charges that are above the UCR amount for any non-emergent out-of-network services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain prior	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

	authorization, and health care this plan doesn't cover.	

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider (You will pay the least)	Your cost if you use an Out of Network Provider (You will pay the most)	Limitations & Exceptions *For authorized services provided out-of-network (including Urgent Care visits) member may be liable for excess UCR. Emergency Room services are not subject to UCR.
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit 10% coinsurance after deductible for other outpatient services.	30% coinsurance after deductible	e-Visits for dependent members under the age of 26 are covered with a $20 copay. e-Visits for all other members are covered with a $20 copay.
	Specialist visit	$30 copay/visit 10% coinsurance after deductible for other outpatient services.	30% coinsurance after deductible	----------none----------
	Other practitioner office visit	Chiro/Adult Vision: $30 copay/visit 10% coinsurance after deductible for other outpatient services.	Chiro/Adult Vision: 30% coinsurance after deductible.	No coverage for Out-of-Network Hearing Exams. Benefits are not available for care that is Maintenance and Supportive Care or Long-term Therapy. Glasses/contacts for Adult Routine Vision are not covered.
	Preventive care/screening/ immunization Includes Breast Cancer Mammography for women over 40 and Colorectal Cancer Screening for adults over 50. For a full listing of preventive care services visit unityhealth.com.	No charge	30% coinsurance after deductible	Coverage is limited to preventive services as defined by the Affordable Care Act. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	30% coinsurance after deductible	----------none----------
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	30% coinsurance after deductible	----------none----------

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider (You will pay the least)	Your cost if you use an Out of Network Provider (You will pay the most)	Limitations & Exceptions *For authorized services provided out-of-network (including Urgent Care visits) member may be liable for excess UCR. Emergency Room services are not subject to UCR.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.unityhealth.com/drugformulary	Preferred Generics | Tier 1	Value Tier: $5 copay All others: $10 copay	Value Tier: $5 copay All others: $10 copay	Multiple copays will apply for claims of greater than 30 day supply when covered; for claims of 31 to 60 days supply, two copays will apply, and for claims of 61 to 90 days supply, three copays will apply.
	Preferred Brands | Tier 2	Value Tier: $5 copay All others: $25 copay	Value Tier: $5 copay All others: $25 copay	
	Non-Preferred Brands & Generics | Tier 3	$50 copay	$50 copay	
	Specialty drugs | Tier 4	$25 copay for Preferred $50 copay for Non-preferred	$25 copay for Preferred $50 copay for Non-preferred	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	30% coinsurance after deductible	Prior authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$125 copay/visit	$125 copay/visit	----------none----------
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	----------none----------
	Urgent care	$60 copay/visit	30% coinsurance after deductible	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	30% coinsurance after deductible	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance after deductible	
If you are in need of Transplant Services	Various	See the specific "Services You May Need" category for applicable copay, coinsurance and deductible. Prior Authorization is required.	Not Covered	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider (You will pay the least)	Your cost if you use an Out of Network Provider (You will pay the most)	Limitations & Exceptions *For authorized services provided out-of-network (including Urgent Care visits) member may be liable for excess UCR. Emergency Room services are not subject to UCR.
If you have mental health, behavioral health, or substance abuse needs, including Autism Spectrum Disorder services	Outpatient services	$30 copay/visit 10% coinsurance after deductible for other outpatient services.	30% coinsurance after deductible	Benefits are not available for care that is Maintenance and Supportive Care or Long-term therapy.
	Inpatient services	10% coinsurance after deductible	30% coinsurance after deductible	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
If you are pregnant	Office visits	$30 copay/visit 10% coinsurance after deductible for other outpatient services.	30% coinsurance after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prior authorization is required for inpatient services. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Childbirth/delivery professional services	10% coinsurance after deductible	30% coinsurance after deductible	
	Childbirth/delivery facility services	10% coinsurance after deductible	30% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	30% coinsurance after deductible	Coverage is limited to 60 visits per Benefit Year. Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Rehabilitation services	10% coinsurance after deductible	30% coinsurance after deductible	Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year. Cardiac Rehab is limited to 36 visits per event.

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	Habilitation services	10% coinsurance after deductible	30% coinsurance after deductible	Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year. Prior Authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Skilled nursing care	10% coinsurance after deductible	30% coinsurance after deductible	Coverage limited to 90 days per confinement. Prior Authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Durable medical equipment For details on Ostomy Supply coverage, refer to your Certificate of Coverage.	20% coinsurance	20% coinsurance	Coverage for -- Foot Orthotics: Limited to one pair per Benefit Year. Hearing Aids: Limited to one per ear every 36 months. To obtain the list of covered hearing aid models log onto unityhealth.com/hearing aids or contact Customer Service. Prior authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	*For authorized services provided out-of-network (including Urgent Care visits) member may be liable for excess UCR. Emergency Room services are not subject to UCR.
	Hospice services	10% coinsurance after deductible	30% coinsurance after deductible	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
If your child (under 19) needs dental or eye care	Children's eye exam	No charge	30% coinsurance after deductible	Limited to one exam per Benefit Year.
	Children's glasses	Not Covered	Not Covered	----------none----------
	Dental Care	Not Covered	Not Covered	----------none----------
If you need oral surgery	Oral surgery	10% coinsurance	30% coinsurance	Coverage is limited to procedures listed in your Certificate of Coverage.

Important: This Schedule of Benefits is only a summary of your coverage. For a complete description of your benefits, and the restrictions, exclusions and limitations that apply, read the Certificate of Coverage. Benefits are provided as stated on this Schedule only when services are received according to the terms set forth in the Certificate of Coverage.

Annual Out-of-Pocket Limit: Once the Annual Out-of-Pocket limit has been satisfied, Unity pays 100% of covered services for the remainder of the Benefit Year, excluding any amounts the Member pays in excess of the Usual, Customary and Reasonable Charge. Such amounts do not count toward satisfaction of the Annual Out-of-Pocket limit.

Prior Authorization: Prior Authorization is required for coverage of certain services. These services are listed on Unity's website at unityhealth.com. You may also call Unity Customer Service for information.