



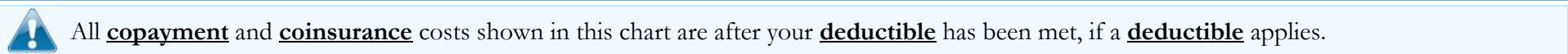
## HSA 2000 Plan



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 Vontier Employment Services Human Resource Department or call 1-833-805-7672. 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](http://www.healthcare.gov/sbc-glossary) or call 1-833-805-7672 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<u>Network</u> : \$2,000 Individual / \$4,000 Family <u>Non-Network</u> : \$3,500 Individual / \$7,000 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive Care</u> is 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other <u>deductibles</u> for specific services?</b>	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.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For <u>network provider</u> : \$4,000 Individual / \$8,000 Family For <u>out-of-network providers</u> : \$8,000 Individual / \$16,000 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> , the overall family <u>out-of-pocket limits</u> must be met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain prior authorization for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .

Important Questions	Answers	Why This Matters:
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-833-805-7672 for a list of <u>network providers</u> .	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 charge</u> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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
		Network Provider (You will pay the least)	Out-of-Network Provider (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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Virtual visit – in-network 20% <u>coinsurance</u> after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . No virtual visit coverage for out of <u>network</u> . If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or co-ins may apply.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or co-insurance may apply.
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge	40% <u>coinsurance</u>	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>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for certain services or \$300 penalty 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)	
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b> <b>More information about <u>prescription drug coverage</u> is available at <a href="http://VontierBenefits.com">VontierBenefits.com</a></b>	Generic Drugs (Tier 1)	Retail: 20% <u>coinsurance</u> (after <u>deductible</u> ); Mail: 20% <u>coinsurance</u> (after <u>deductible</u> )	Not covered	Up to a 30 day maximum for retail scripts; 90 day maximum for mail scripts; utilization management required for certain drugs; all cost-sharing may be waived for certain ACA mandated preventive drugs. Deductible may be waived for certain non-ACA preventive drugs. Under Prudent, specialty drugs have a \$0 copay after the deductible is met; if opted out of Prudent, specialty drug cost share is 30%.
	Preferred brand drugs (Tier 2)	Retail: 20% <u>coinsurance</u> (after <u>deductible</u> ); Mail: 20% <u>coinsurance</u> (after <u>deductible</u> )	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: 20% <u>coinsurance</u> (after <u>deductible</u> ); Mail: 20% <u>coinsurance</u> (after <u>deductible</u> )	Not covered	
	<u>Specialty drugs</u> (Tier 4)	Same as other drugs	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network or \$300 penalty applies.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network or \$300 penalty applies.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior Authorization required for certain services out-of-network or \$300 penalty applies.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior Authorization required out-of-network for inpatient facility or \$300 penalty applies.
<b>If you are pregnant</b>	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior Authorization required for out-of-network for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or \$300 penalty applies. Cost sharing does not apply for preventive services. 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>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 120 visits per calendar year for <u>Home Health Care</u> . Prior Authorization required out-of-network for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN) or \$300 penalty applies.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 100 visits per calendar year physical, speech, and occupational combined.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Habilitation Services</u> are provided, and limits are combined with <u>Rehabilitation Services</u> above

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>Skilled nursing care</u>	20% coinsurance	40% coinsurance	<u>Prior Authorization</u> required out-of-network or \$300 penalty applies.
	<u>Durable medical equipment</u>	20% coinsurance	40% coinsurance	<u>Prior Authorization</u> required out-of-network for DME over \$1,000 or \$300 penalty applies.
	<u>Hospice services</u>	20% coinsurance	40% coinsurance	<u>Prior Authorization</u> required out-of-network before admission for an inpatient stay in a hospice facility or \$300 penalty applies.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	1 exam per year
	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"> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine foot care</li> </ul>
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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"> <li>Acupuncture</li> <li>Adult routine vision exam (i.e. refraction)</li> <li>Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Weight loss programs</li> </ul>
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**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/](http://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: 1-833-805-7672 or visit Not Available or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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 1-833-805-7672.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-805-7672.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-805-7672.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-833-805-7672 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-805-7672.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-805-7672.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-805-7672.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-833-805-7672.

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

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## 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>	\$2,000
■ <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:**

#### Cost Sharing

<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,000

#### What isn't covered

Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$4,070</b>

### 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>	\$2,000
■ <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:**

#### Cost Sharing

<u>Deductibles</u>	\$1,100
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0

#### What isn't covered

Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$5,400</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <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:**

#### Cost Sharing

<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200

#### What isn't covered

Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$2,210</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: UnitedHealthcare .