Specialized Medical Plan.: Bind On-Demand Health Insurance

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 these websites[1]. 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 https://www.healthcare.gov/sbc-glossary/ or call 1–(833)-576-6494.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes	There is no deductible, but a copayment may apply. For example, this plan covers certain preventive services without cost-sharing. 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 covered services.
What is the out-of-pocket limit for this plan?	For network providers: $3,500 individual / $7,000 family For out-of-network providers: $7,000 individual / $14,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. Copayments for covered health care services, including Add-In procedures and covered prescriptions, count toward your out-of-pocket limit. 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 not included in the out-of-pocket limit?	Premiums, balance billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Visit choosebind.com/specialized or mybind.com or call 1–(833)-576-6494 for a list of network providers[1].	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

[1]During open enrollment, visit choosebind.com/specialized and use the access code: active employees - Specialized2020; UT employees – SpecializedUT2020. After you enroll, visit mybind.com.

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[2]		Limitations, Exceptions, & Other Important Information[3]
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 - $30 copayment/visit	$60 copayment/visit	Complex Office Visit for Chemodenervation, Vein ablation, implantation of drug delivery device, Eye cryotherapy and photocoagulation: network providers $75 copayment/visit and out-of-network provider provider $150 copayment /visit
	Specialist visit	$10 - $30 copayment/visit	$60 copayment/visit	
	Preventive care/screening/ immunization	No charge	$45 copayment/visit	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 (e.g. x-ray, blood work)	No charge	No charge	Higher copayments apply to genetic testing; network providers $75 copayment/visit and out-of-network provider $150 copayment /visit
	Imaging (CT/PET scans, MRIs)	$75 - $400 copayment/visit	$800 copayment/visit	Preauthorization is required for certain imaging tests.

2 The full range of copayments may not be available in all areas or for all services. Also, if you use preferred, high-value providers you may be able to reduce your copayments.

3 For more information about your copayments, preferred, high-value providers and about plan limitations and exceptions, see the plan document, visit one of the Bind websites listed in the footnote on page 1, or call Bind Help.

Common Medical Event	Services You May Need	What You Will Pay[2]		Limitations, Exceptions, & Other Important Information[3]
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at one of the Bind websites listed in the footnote on page 1.	**Tier 1 drugs**	**30-Day Supply** $5 copayment at Preferred Pharmacies; $10 copayment at other network pharmacies **90-Day Supply** $15 copayment at Preferred Pharmacies or Kroger Mail Order; $25 copayment at other network pharmacies	Not covered	Certain Tier 1 drugs are available with $0 copayments, including prescribed generic contraceptives and tobacco cessation medications. To learn more about drug tiers and about copayments for specific drugs, visit one of the Bind websites listed in the footnote on page 1. Preauthorization is required for certain drugs.
	Tier 2 drugs	**30-Day Supply** $30 copayment at Preferred Pharmacies and other network pharmacies **90-Day Supply** $75 copayment at Preferred Pharmacies, other network pharmacies or Kroger Mail Order	Not covered	
	Tier 3 drugs	**30-Day Supply** $60 copayment at Preferred Pharmacies and other network pharmacies **90-Day Supply** $150 copayment at Preferred Pharmacies, other network pharmacies or Kroger Mail Order	Not covered	
	Specialty drugs	**30-Day Supply** Tier 1: $150 copayment Tier 2: $200 copayment Tier 3: $250 copayment	Not covered	Specialty drugs are not covered at 90 day supplies. Preauthorization is required for certain Specialty drugs.

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Common Medical Event	Services You May Need	What You Will Pay[2]		Limitations, Exceptions, & Other Important Information[3]
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility access (e.g., ambulatory surgery center)	$600 copayment/visit	$1,200 copayment/visit	One copayment for all covered services related to outpatient surgery. Preauthorization is required for certain outpatient surgery.
	Physician/surgeon fees	Included in the facility copayment	Included in the facility copayment	
If you need immediate medical attention	Emergency room care	$250 copayment/visit	$250 copayment/visit	Copayment is waived if admitted within 24 hours.
	Emergency medical transportation	$350 copayment/trip	$350 copayment/trip	None
	Urgent care	$60 copayment/visit	$200 copayment/visit	None
If you have a hospital stay	Facility access (e.g., hospital room)	$1,000 copayment/visit	$2,000 copayment/visit	One copayment for all covered services related to hospital stay. Preauthorization is required for non-emergency facility admissions and inpatient surgery.
	Physician/surgeon services	Included in the facility copayment	Included in the facility copayment	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Home/Clinic**: $20 copayment/visit **Outpatient Hospital**: $600 copayment/visit	**Home/Clinic**: $60 copayment/visit **Outpatient Hospital**: $1,200 copayment/visit	Preauthorization is required for certain outpatient services.
	Inpatient services	$1,000 copayment/visit	$2,000 copayment/visit	Preauthorization is required for certain inpatient services.
If you are pregnant	Office visits	No charge	$45 copayment/visit	Cost sharing does not apply to preventive services with network providers.

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Common Medical Event	Services You May Need	What You Will Pay[2]		Limitations, Exceptions, & Other Important Information[3]
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	Included in the facility copayment	Included in the facility copayment	One copayment for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother.
	Childbirth/delivery facility services	$400 - $1,000 copayment/visit	$2,000 copayment/visit	
If you need help recovering or have other special health needs	Home health care	$20 copayment/visit	$60 copayment/visit	Visit Limit: 120 for home health care per person per year (visit maximums are a combination of in-and-out network services) Preauthorization is required for certain home health services.
	Rehabilitation services	$10 - $80 copayment/visit	$160 copayment/visit	Visit limits per person per calendar year, network providers and out-of-network providers combined. 60 visit maximum for occupational therapy 60 visit maximum for physical therapy 60 visit maximum for speech therapy
	Habilitation services	$10 - $80 copayment/visit	$160 copayment/visit	
	Skilled nursing care	$1,000 copayment/visit	$2,000 copayment/visit	Visit Limit: 120 days for skilled nursing care per person per year (the day limit maximum is a combination of in-and-out network services)
	Durable medical equipment (DME)	$0 - $500 copayment/equipment based on DME tier	$20 - $1,000 copayment/equipment based on DME tier	For DME tiers and limitations, visit one of the Bind websites listed in the footnote on page 1. Preauthorization is required for certain DME.

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Common Medical Event	Services You May Need	What You Will Pay[2]		Limitations, Exceptions, & Other Important Information[3]
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	**Home/Clinic**: $20 copayment **Inpatient**: $1,000 copayment	**Home/Clinic**: $60 copayment **Inpatient**: $2,000 copayment	Preauthorization is required for certain hospice services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (routine)
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Weight loss programs

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

- Acupuncture (Visit Limit: 60 per person per year)
- Bariatric Surgery and 44 other "Add-Ins" if you purchase the Add-In coverage in advance of receiving surgery and pay the additional copayment(s) and premium(s)[4]
- Chiropractic care (Visit Limit: 60 per person per year)
- Hearing aids (once every 36 months)
- Infertility Treatment (limitations apply)
- Routine foot care (for certain conditions)

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[3] For more information about your copayments, preferred, high-value providers and about plan limitations and exceptions, see the plan document, visit one of the Bind websites listed in the footnote on page 1, or call Bind Help.

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 the agency is the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or 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 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: Bind at 1–(833)-576-6494; for the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

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)-576-6494.

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

[2] The full range of copayments may not be available in all areas or for all services. Also, if you use preferred, high-value providers you may be able to reduce your copayments.
[3] For more information about your copayments, preferred, high-value providers and about plan limitations and exceptions, see the plan document, visit one of the Bind websites listed in the footnote on page 1, or call Bind Help.

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 plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) copayment	$1000
Other copayments	$90

This EXAMPLE event includes services like:
Specialist office visits *(prenatal 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	
Deductibles	$0
Copayments	$1,090
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,100**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$0
Other copayments	$765

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$795
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$850**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayments	$60
Hospital (facility) copayment	$250
Other copayments	$490

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

[4]The plan includes both Core benefits and also "Add-In" benefit options too numerous to describe in this summary. Add-Ins provide benefits to participants with relevant adverse health factors that may not be covered under Core. Copayments for Add-Ins may vary from the examples in this summary. For more information about coverage and options, see the most recent plan document or visit one of the Bind websites listed in the footnote on page 1.