
 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.whyuhc.com or by calling 1-800-782-3740. 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 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$1,800 Individual / \$3,600 Family per Contract 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.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> is covered before you meet your deductible.	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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Network: \$5,500 Individual / \$8,900 Family	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 out-of-pocket limit?	Premiums, <u>balance-billing charges</u> (unless <u>balanced billing</u> is prohibited), and 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 limit</u> .
Will you pay less if you use a network provider?	Yes. See www.whyuhc.com or call 1-800-782-3740 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.
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
		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	0% <u>coinsurance</u>	Not Covered	Virtual visits (Telehealth) - 0% <u>coinsurance</u> by a Designated Virtual Network Provider.
	Specialist visit	0% <u>coinsurance</u>	Not Covered	None
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing/Office Lab: \$40 <u>copay</u> per service Free Standing/Office X-ray: \$100 <u>copay</u> per service Hospital Lab: \$40 <u>copay</u> per service Hospital X-ray: \$100 <u>copay</u> per service	Not Covered	If services are performed in a <u>Primary care physicians office</u> , additional <u>copay</u> , <u>deductible/coinsurance</u> may apply.
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: \$200 <u>copay</u> per service Hospital: \$200 <u>copay</u> per service	Not Covered	If services are performed in a <u>Primary care physician or Specialist office</u> , additional <u>copay</u> , <u>deductible/coinsurance</u> may apply.

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.whyuhc.com	Tier 1 - Your Lowest-Cost Option	Retail: \$5 <u>copay</u> Mail-Order: \$12.50 <u>copay</u>	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31-day supply Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network pharmacy. If you use an out-of-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Prescription Drug List (PDL): Advantage w/ Core Plus Preventive. Network: National. If a dispensed drug has a chemically equivalent drug, the cost difference between drugs in addition to any applicable <u>copay</u> and/or <u>coinsurance</u> may be applied. Certain preventive medications, zero cost share medications, and Tier 1 contraceptives are covered at No Charge. <u>Copay</u> is per prescription order up to the day supply limit listed above.
	Tier 2 - Your Midrange-Cost Option	Retail: \$45 <u>copay</u> Mail-Order: \$112.50 <u>copay</u>	Not Covered	
	Tier 3 - Your Midrange-Cost Option	Retail: \$90 <u>copay</u> Mail-Order: \$225 <u>copay</u>	Not Covered	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$800 <u>copay</u> per visit	Not Covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$500 <u>copay</u> per visit	\$500 <u>copay</u> per visit	None
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Urgent care</u>	0% <u>coinsurance</u>	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,200 <u>copay</u> per admission	Not Covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not Covered	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>coinsurance</u>	Not Covered	Network partial hospitalization/intensive outpatient treatment/high intensity outpatient: 0% <u>coinsurance</u> Intensive Behavior Therapy (ABA): 0% <u>coinsurance</u>
	Inpatient services	\$1,200 <u>copay</u> per admission	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply.
	Childbirth/delivery professional services	0% <u>coinsurance</u>	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery facility services	\$1,200 <u>copay</u> per admission	Not Covered	Additional <u>copays</u> , <u>deductibles</u> , <u>coinsurance</u> may apply.
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	Not Covered	Limited to 60 visits per calendar year. Home intravenous infusion is not covered out-of-Network.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	Not Covered	Limits per calendar year: Physical, Occupational, Speech: 60 visits (combined). Pulmonary & Cardiac: Unlimited.
	<u>Habilitation services</u>	0% <u>coinsurance</u>	Not Covered	Limits per calendar year: Physical, Occupational, Speech: 60 visits (combined). Cost share applies for outpatient services only.
	<u>Skilled nursing care</u>	\$1,200 <u>copay</u> per admission	Not Covered	Skilled nursing facility is unlimited.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	Not Covered	None
	<u>Hospice services</u>	0% <u>coinsurance</u>	Not Covered	None
	If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered
Children's glasses		50% <u>coinsurance</u>	Not Covered	One pair every 12 months.
Children's dental check-up		0% <u>coinsurance</u>	Not Covered	Cleanings covered 2 times per 12 months.

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 <u>excluded services</u> .)		
• Acupuncture	• Cosmetic surgery	• Dental care (Adult)
• Long-term care	• Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)
• 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.)

- Bariatric surgery
- Infertility treatment- artificial insemination only
- Chiropractic care
- Private Duty Nursing
- Hearing aids

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: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration, you may also contact us at 1-800-782-3740 . 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: 1-800-782-3740 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the New York Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov.

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 1-800-782-3740.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-782-3740.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-782-3740.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-782-3740 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-782-3740.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-782-3740.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-800-782-3740.

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$1,800	■ The plan's overall deductible	\$1,800	■ The plan's overall deductible	\$1,800
■ Specialist coinsurance	0%	■ Specialist coinsurance	0%	■ Specialist coinsurance	0%
■ Hospital (facility) copayment	\$1,200	■ Hospital (facility) copayment	\$1,200	■ Hospital (facility) copayment	\$1,200
■ Other coinsurance	0%	■ Other coinsurance	0%	■ Other coinsurance	0%
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$1,800	Deductibles	\$1,700	Deductibles	\$1,800
Copayments	\$1,400	Copayments	\$0	Copayments	\$400
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$3,260	The total Joe would pay is	\$1,700	The total Mia would pay is	\$2,200

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