
 **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, call 1-800-258-6534. 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.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-258-6534 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$400 per individual / \$800 per family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes: Physician office visits, routine mammograms, other specified wellness benefits and the first \$200 incurred within 72 hours following an accident.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$100 per visit to a hospital emergency room unless admitted to the hospital. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$4,000 per family for medical expenses, \$4,550 per person/\$9,100 per family for prescription drugs	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Precertification penalties, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges and health care this <a href="#">plan</a> doesn't cover, such as non-emergency health care charges received from an <a href="#">out-of-network</a> provider.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.welcometouhc.com/uhss">www.welcometouhc.com/uhss</a> or call 1-800-258-6534 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . The plan excludes <a href="#">out-of-network</a> charges except in limited circumstances. Thus you will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	15% <a href="#">coinsurance</a>	Not covered	Not subject to <a href="#">deductible</a> . First \$200 incurred 72 hours following an accident paid in full. <a href="#">Out-of-network providers</a> covered at <a href="#">in-network</a> level if you live out-of-area (50 miles from nearest qualified <a href="#">network provider</a> ).
	<a href="#">Specialist</a> visit	15% <a href="#">coinsurance</a>	Not covered	Maximum annual benefit of \$500 for treatment by a chiropractor. Chiropractic benefits are limited to x-rays and spinal manipulations only. Also, see above.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	The following services are covered, and are not subject to the <a href="#">deductible</a> : <ul style="list-style-type: none"> <li>• Routine exams, immunizations, pap smears, audiograms, PSAs and mammograms; and</li> <li>• Routine colonoscopies for employees and spouses age 50 or older, once every 5 years.</li> </ul> You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	15% <a href="#">coinsurance</a>	Not covered	Not subject to <a href="#">deductible</a> if performed in conjunction with a physician's office visit. First \$200 incurred within 72 hours following an accident paid in full. <a href="#">Out-of-network providers</a> covered at <a href="#">network</a> level if you live out-of-area (50 miles from nearest qualified <a href="#">network provider</a> ). Additionally, <a href="#">out-of-network</a> lab and x-ray services will be covered at the <a href="#">in-network</a>

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)	
<b>If you have a test</b>				level if you utilize a <u>network</u> physician.
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	Not covered	First \$200 incurred within 72 hours following an accident paid in full. <u>Out-of-network providers</u> covered at <u>network</u> level if you live out-of-area (50 miles from nearest qualified <u>network</u> provider).
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available by calling 1-866-516-3121.	Tier 1 drugs (Generic)	\$5 <u>copay</u> 30 day supply/ \$10 <u>copay</u> 90 day supply	Not covered	Supply limit 30 days retail / 90 days mail order. Coverage for acid reflux medication or drugs that are available over-the-counter are excluded, unless otherwise covered pursuant to applicable law.
	Tier 2 drugs (Brand)	\$50 <u>copay</u> 30 day supply/\$100 <u>copay</u> 90 day supply	Not covered	See above. The use of Tier 2 drugs instead of Tier 3 will help reduce your out-of-pocket costs.
	Tier 3 drugs (Brand)	\$50 <u>copay</u> 30 day supply/\$100 <u>copay</u> 90 day supply	Not covered	See above. Many Tier 3 drugs have lower cost options in Tier 1 or Tier 2.
	<a href="#">Specialty drugs</a>	30% <u>coinsurance</u>	Not covered	Must be acquired through OptumRx's Specialty Drug Program. Certain approved specialty drugs may be provided and administered by a <u>network</u> physician, in which case they are paid as medical benefits – 15% <u>coinsurance</u> and subject to the <u>deductible</u> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	Not covered	First \$200 incurred within 72 hours following an accident paid in full. <u>Out-of-network providers</u> covered at <u>network</u> level if you live out-of-area (50 miles from nearest qualified <u>network</u> provider).
	Physician/surgeon fees	15% <u>coinsurance</u>	Not covered	See 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)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	15% <u>coinsurance</u>	15% <u>coinsurance</u> (But see the Limitations)	Subject to \$100 emergency room <u>deductible</u> . First \$200 incurred within 72 hours after an accident paid in full. Out-of-network charges are subject to in-network benefit for emergency situations. Participant cost share will be the same for all emergency care.
	<a href="#">Emergency medical transportation</a>	15% <u>coinsurance</u>	15% <u>coinsurance</u> (But see the Limitations)	First \$200 incurred within 72 hours after an accident paid in full. Air ambulance covered up to maximum amount allowed by Medicare. Out-of-network charges are subject to in-network benefit for emergency situations. Participant cost share will be the same for all emergency care.
	<a href="#">Urgent care</a>	15% <u>coinsurance</u>	Not covered	First \$200 incurred within 72 hours following an accident paid in full. Out-of-network charges are subject to in-network benefit for emergency situations. Participant cost share will be the same for all emergency care.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	Not covered	Hospital stays must be pre-certified. Call 1-877-211-6452 to precertify. <u>Out-of-network providers</u> covered at <u>network</u> level if you live out-of-area (50 miles from nearest qualified <u>network provider</u> ). Additionally, <u>out-of-network ancillary providers</u> (anesthesiologists, radiologists, pathologists, lab services) will be covered at the <u>in-network</u> level if you utilize a <u>network</u> facility.
	Physician/surgeon fees	15% <u>coinsurance</u>	Not covered	<u>Out-of-network providers</u> covered at <u>network</u> level if you live out-of-area (50 miles from nearest qualified <u>network provider</u> ).

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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	15% <u>coinsurance</u>	Not covered	<u>Out-of-network providers</u> covered at <u>network</u> level if you live out-of-area (50 miles from nearest qualified <u>network</u> provider).
	Inpatient services	15% <u>coinsurance</u>	Not covered	See above. Additionally, <u>out-of-network ancillary providers</u> (anesthesiologists, radiologists, pathologists, lab services) will be covered at the <u>in-network</u> level if you utilize a <u>network</u> attending physician and facility.
<b>If you are pregnant</b>	Office visits	15% <u>coinsurance</u>	Not covered	<b>Coverage is provided for employees and spouses only.</b> <u>Out-of-network providers</u> covered at <u>network</u> level if you live out-of-area (50 miles from nearest qualified <u>network</u> provider).
	Childbirth/delivery professional services	15% <u>coinsurance</u>	Not covered	<b>Coverage is provided for employees and spouses only.</b> See above. Additionally, <u>out-of-network ancillary providers</u> (anesthesiologists, radiologists, pathologists, lab services) will be covered at the <u>in-network</u> level if you utilize a <u>network</u> facility.
	Childbirth/delivery facility services	15% <u>coinsurance</u>	Not covered	<u>Out-of-network providers</u> covered at <u>network</u> level if you live out-of-area (50 miles from nearest qualified <u>network</u> provider).
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	15% <u>coinsurance</u>	Not covered	<u>Out-of-network providers</u> covered at <u>network</u> level if you live out-of-area (50 miles from nearest qualified <u>network</u> provider).
	<a href="#">Rehabilitation services</a>	15% <u>coinsurance</u>	Not covered	See above.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	None
	<a href="#">Durable medical equipment</a>	15% <u>coinsurance</u>	Not covered	See above.
<a href="#">Hospice services</a>	15% <u>coinsurance</u>	Not covered	See above.	
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	No charge	None

## 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>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li><li>• Gene therapy</li></ul> | <ul style="list-style-type: none"><li>• Habilitation services</li><li>• Hearing aids</li><li>• Infertility treatment</li></ul> | <ul style="list-style-type: none"><li>• Long-term care</li><li>• Routine eye care (Adult)</li><li>• Weight loss programs, excluding screening and counseling</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.)

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|---|--|--|
| <ul style="list-style-type: none"><li>• Chiropractic care</li><li>• Dental care (Adult)</li></ul> | <ul style="list-style-type: none"><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> |
|---|--|--|

**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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272). 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 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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or contact the office of the plan at 1-800-258-6534.

### 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 1-800-258-6534.

————— *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 [plan's](#) overall [deductible](#) \$400
- [Specialist](#) [*cost sharing*] 15%
- Hospital (facility) [*cost sharing*] 15%
- Other [*cost sharing*] 15%

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$5
Coinsurance	\$1,832
<i>What isn't covered</i>	
Limits or exclusions	\$61
<b>The total Peg would pay is</b>	<b>\$2,298</b>

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

- The [plan's](#) overall [deductible](#) \$400
- [Specialist](#) [*cost sharing*] 15%
- Hospital (facility) [*cost sharing*] 15%
- Other [*cost sharing*] 15%

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$660
Coinsurance	\$253
<i>What isn't covered</i>	
Limits or exclusions	\$22
<b>The total Joe would pay is</b>	<b>\$1,335</b>

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

- The [plan's](#) overall [deductible](#) \$400
- [Specialist](#) [*cost sharing*] 15%
- Hospital (facility) [*cost sharing*] 15%
- Other [*cost sharing*] 15%

**This EXAMPLE event includes services like:**  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$100
Coinsurance	\$345
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$845</b>