This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-800-736-1364.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network: $3,000 Individual / $9,000 Family** Doesn't apply to, copays and other services listed below as "No Charge". Per Calendar Year	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. Prescription Drugs- **$750 per covered person**	You must pay all of the plan costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **Network: $6,350 Individual/ $12,700 Family**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain notification for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses network **providers**. If you use a non-network **provider** your cost may be more. For a list of participating providers, see www.myuhc.com or call the toll-free number on the back of your member ID card.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the Common Medical Events chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist.**	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-736-1364 or visit us at www.myuhc.com. If you aren't clear about any of the terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call the phone number above to request a copy. **This is only a summary**.
It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% co-insurance after deductible is met	Not Covered	If you receive services in addition to office visi additional copays, deductibles, or co-ins may apply. No non-network coverage.
	Specialist visit	30% co-insurance after deductible is met	Not Covered	
	Other practitioner office visit	30% co-insurance for Manipulative (Chiropractic) services	Not Covered	Limited to 20 visits of Manipulative (Chiropractic) services per calendar year. No non-network coverage.
	Preventive care/screening/immunizatio n	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. No non-network coverage.
If you have a test	Diagnostic test (x-ray, blood work)	30% co-insurance after deductible is met	Not Covered	---------- None ----------
	Imaging (CT/PET scans, MRIs)	30% co-insurance after deductible is met	Not Covered	---------- None ----------
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest-Cost Option	Retail & Mail Order: 10% co-insurance or $10 minimum, after deductible is met	Not Covered	Provider means pharmacy for purposes of this sectio **Retail:** Up to a 31 day supply **Mail-Order:** Up to a 90 day supply

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at www. myuhc.com.	Tier 2 – Your Mid-Range Cost Option	Retail & Mail Order: 25% co-insurance or $25 minimum, after deductible is met	Not Covered	**Prescription Drug Deductible:** $240 per covered person **Prescription Drug Out-of-Pocket Max:** $3,650 per covered person See the website listed for information on drugs covered by your plan.
	Tier 3 – Your Highest-Cost Option	Retail & Mail Order: 40% co-insurance or $40 minimum, after deductible is met	Not Covered	
	Tier 4 – Additional High-Cost Option	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance after deductible is met	Not Covered	---------- None ----------
	Physician/surgeon fees	30% co-insurance after deductible is met	Not Covered	---------- None ----------
If you need immediate medical attention	Emergency room services	$100 copay, then 30% co-insurance after deductible is met	Same as Network	Copay is waived if you are admitted for Inpatient stay directly from the Emergency Room. Notification is required if confined in a non-Netwo hospital or benefit may be subject to penalty.
	Emergency medical transportation	30% co-insurance after deductible is met	Same as Network	Non- network notification is required or benefit m be subject to penalty.
	Urgent care	30% co-insurance after deductible is met	Not Covered	If you receive services in addition to urgent ca additional deductibles or co-ins may apply. No non-network coverage.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance after deductible is met	Not Covered	---------- None ----------
	Physician/surgeon fee	30% co-insurance after deductible is met	Not Covered	---------- None ----------

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% co-insurance after deductible is met	Not Covered	See your policy or plan document for additional information about EAP benefits. No non-network coverage.
	Mental/Behavioral health inpatient services	30% co-insurance after deductible is met	Not Covered	
	Substance use disorder outpatient services	30% co-insurance after deductible is met	Not Covered	
	Substance use disorder inpatient services	30% co-insurance after deductible is met	Not Covered	
If you are pregnant	Prenatal and postnatal care	30% co-insurance after deductible is met **Deductible applies only to initial office visit	Not Covered	Your cost in this category includes Physician Delivery Charges. Additional copays, deductibles or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge after initial office visit.
	Delivery and all inpatient services	30% co-insurance after deductible is met	Not Covered	Additional deductible or co-ins may apply. You cost for this category includes inpatient service only. No non-network coverage.
If you need help recovering or have other special health needs	Home health care	30% co-insurance after deductible is met	Not Covered	Limited to 30 visits per calendar year. No non-network coverage.
	Rehabilitation services	30% co-insurance after deductible is met	Not Covered	Limited to 20 visits per therapy, per calendar yea No non-network coverage.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation Services.
	Skilled nursing care	30% co-insurance after deductible is met	Not Covered	Limited to 120 visits per calendar year. (combine with Inpatient Rehabilitation) No non-network coverage.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Durable medical equipment	30% co-insurance after deductible is met	Not Covered	Covers 1 per type of DME (including repair/replacement) per year.
	Hospice service	30% co-insurance after deductible is met	Not Covered	---------- None ----------
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to 1 exam per year. *Must be performed as part of the annual physical exam in a provider's office. No coverage non-network
	Glasses	Not Covered	Not Covered	No coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Habilitative Services
- Hearing aids
- Glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture – may be covered with limitations
- Bariatric surgery - may be covered with limitations
- Chiropractic care– may be covered with limitations
- Private-duty nursing
- Routine eye care (Adult) – may be covered with limitations

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-0048. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or visit www.myuhc.com or the Employee Benefits Securit Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.
若需要中文协助，请拨打您会员卡上的电话号码
Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih
Para sa tulong sa Tagalog, tawagan ang numero sa iyong ID card.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,040
- **Patient pays** $4,500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,000
Copays	$0
Coinsurance	$1,300
Limits or exclusions	$200
Total	**$4,500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,520
- **Patient pays** $1,880

Sample care costs:

Prescriptions	$2,90
Medical Equipment and Supplies	$1,30
Office Visits and Procedures	$70
Education	$30
Laboratory tests	$10
Vaccines, other preventive	$10
Total	**$5,40**

Patient pays:

Deductibles	$1,40
Copays	$
Coinsurance	$40
Limits or exclusions	$8
Total	**$1,88**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.