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 1-888-682-4269. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms, see the Glossary. You may view the Glossary at healthcare.gov/sbc-glossary or call 1-888-682-4269 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Single Plan: $3,000 employee Family Plan: $3,000 person/$6,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive services and physician office visits are some of the services covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov /coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Single Plan: $5,000 employee Family Plan: $5,000 person/$10,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. 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 is met.
What is not included in the out-of-pocket limit?	Preauthorization penalties, 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. See hpiTPA.com to access a list of UnitedHealthcare Choice service providers; select the "My Provider Networks" for complete list of or call 1-888-682-4269 for a list of network providers.	This plan uses a provider network. You pay less if you use a provider in the plan's network. You 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 may see a specialist you choose without a referral.

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
		In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit; deductible waived	Not covered	You may have to pay for services that aren't preventive. Ask your provider if services are preventive. Then check what your plan will pay. Preauthorization required for ongoing would care
	Specialist visit	$50 copay/visit; deductible waived	Not covered	
	Preventive care/screening/Immunization	No charge; deductible waived	Not covered	
If you have a test	Diagnostic test--- Blood work X-rays & All Other Diagnostic Tests	No charge; deductible waived 10% coinsurance	Not covered	Preauthorization required for imaging
	Imaging—CT scans, PET scans, MRIs	10% coinsurance	Not covered	
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at truerx.com	Generic drugs— Retail (30 days) Retail (90 days)* or Mail Order (90 days)	$10 copay/prescription $25 copay/prescription	Not covered	Deductible waived. *maintenance drugs only Certain prescription drugs are subject to Step Therapy. You may be required to use different prescription drug or pharmaceutical product(s) first. Specialty medications are excluded from coverage under the Plan. Coverage listed for non-specialty medications greater than $350 for a 30-day supply is only applicable to two fills.
	Preferred brand drugs— Retail (30 days) Retail (90 days)* or Mail Order (90 days)	$35 copay/prescription $87.50 copay/prescription	Not covered	
	Non-preferred brand drugs--- Retail (30 days) Retail (90 days)* or Mail Order (90 days)	$60 copay/prescription $150 copay/prescription	Not covered	
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	Preauthorization required
	Physician/surgeon fees	10% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	**First 2 visits per year:** $500 copay/visit + 10% coinsurance then 10% coinsurance after In-network deductible for subsequent calendar year visits		Copay waived if admitted
	Emergency medical transportation	10% coinsurance after In-network deductible		None
	Urgent care	$75 copay/visit; deductible waived	Not covered	None

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
		In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	Preauthorization required or you pay 10% more
	Physician/surgeon fees	10% coinsurance	Not covered	
If you need mental health, behavioral health or substance abuse services	Outpatient services-- Office visit	$25 copay/visit; deductible waived	Not covered	Preauthorization required Inpatient or you pay 10% more
	Intensive outpatient treatment	No charge; deductible waived		
	Inpatient services	10% coinsurance	Not covered	
If you are pregnant	Office visits Prenatal Care	No charge; deductible waived	Not covered	Maternity care may include tests and services described elsewhere in SBC. Requires preauthorization for stays over 48 hrs (normal delivery)/96 hrs (caesarean) or you pay 10% more
	Postnatal Care	10% coinsurance		
	Childbirth/delivery professional services	10% coinsurance		
	Childbirth/delivery facility services	10% coinsurance		
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Preauthorization required. 60 visits/yr
	Rehabilitation services— Inpatient	10% coinsurance	Not covered	60 days/yr with Skilled nursing care. Preauthorization required for Inpatient or you pay 10% more. 20 visits/yr each for Speech, Occupational & Physical therapies (Preauthorization required after 13 visits each for OT/PT/ST)
	Outpatient	$25 copay/visit; deductible waived	Not covered	
	Habilitation services— Early Intervention	10% coinsurance	Not covered	To age 3 Preauthorization and visits limits based on services provided
	Developmental Delay	10% coinsurance	Not covered	
	Skilled nursing care	10% coinsurance	Not covered	60 days/yr with Inpatient rehab. Preauthorization required or you pay 10% more
	Durable medical equipment	10% coinsurance	Not covered	Please refer to plan document for items requiring preauthorization
	Hospice services	10% coinsurance	Not covered	Preauthorization required for Inpatient
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	n/a
	Children's glasses	Not covered	Not covered	n/a
	Children's dental check-up	Not covered	Not covered	n/a

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.)		
• Acupuncture	• Bariatric Surgery	• Cosmetic surgery
• Dental care (routine child & adult)	• Infertility treatment	• Long term care
• Non-emergency care when traveling outside U.S.	• Private Duty Nursing	• Routine eye care (adult & child)
• 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.)		
• Chiropractic care (20 visits/yr)	• Hearing aids ($2,500/aid/ear/3 yrs)	

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 U.S. Department of Labor, Employee Benefits 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, you can contact the plan at 1-888-682-4269. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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 1-888-682-4269
Portuguese (Português): De assistència em Português, ligue 1-888-682-4269
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-682-4269

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)

- **The plan's overall *deductible*** **$3,000**
- **Specialist *copayment*** **$50**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

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	$3,000
Copayments	$10
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,670**

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

- **The plan's overall *deductible*** **$3,000**
- **Specialist *copayment*** **$50**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

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	
Deductibles	$800
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

- **The plan's overall *deductible*** **$3,000**
- **Specialist *copayment*** **$50**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *copayment*** **$25**

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	
Deductibles	$1,300
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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