



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:
<u>What is the overall deductible?</u>	Single Plan: \$4,000 employee Family Plan: \$4,000 person/\$8,000 family	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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. In-network <u>preventive services</u> are covered before you meet your <u>deductible</u> .	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 healthcare.gov /coverage/preventive-care-benefits.
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	Single Plan: \$6,000 employee Family Plan: \$6,000 person/\$12,000 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> is met.
<u>What is not included in the out-of-pocket limit?</u>	Preauthorization penalties, <u>premiums</u> , <u>balance-billing</u> charges 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> .
<u>Will you pay less if you use a network provider?</u>	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 <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You pay less if you use a <u>provider</u> in the <u>plan's network</u> . You 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</u> charge 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.
<u>Do you need a referral to see a specialist?</u>	No.	You may see a <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
		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	10% <u>coinsurance</u>	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if services are <u>preventive</u> . Then check what your <u>plan</u> will pay. <u>Prauthorization</u> required for ongoing wound care
	<u>Specialist</u> visit	10% <u>coinsurance</u>	Not covered	
	<u>Preventive</u> care/ <u>screening</u> / <u>Immunization</u>	No charge; <u>deductible</u> waived	Not covered	
If you have a test	<u>Diagnostic</u> test (X-rays, Blood work)	10% <u>coinsurance</u>	Not covered	<u>Prauthorization</u> required for imaging.
	Imaging (CT scans, PET scans, MRIs)	10% <u>coinsurance</u>	Not covered	
If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at truerx.com	Generic drugs— Retail (30 days) Retail (90 days)* or Mail Order (90 days)	\$10 <u>copay</u> /prescription \$25 <u>copay</u> /prescription	Not covered	<u>Deductible</u> applies except to <u>preventive care</u> drugs. *maintenance drugs only
	Preferred brand drugs— Retail (30 days) Retail (90 days)* or Mail Order (90 days)	\$35 <u>copay</u> /prescription \$87.50 <u>copay</u> /prescription	Not covered	Certain <u>prescription drugs</u> are subject to Step Therapy. You may be required to use different <u>prescription drug</u> /pharmaceutical product(s) first.
	Non-preferred brand drugs--- Retail (30 days) Retail (90 days)* or Mail Order (90 days)	\$60 <u>copay</u> /prescription \$150 <u>copay</u> /prescription	Not covered	<u>Specialty</u> medications are excluded from coverage under the Plan.
	<u>Specialty</u> drugs	Not covered	Not covered	Coverage listed for non- <u>specialty</u> medications greater than \$350 for a 30-day supply is only applicable to two fills.
	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	Not covered	<u>Prauthorization</u> required
If you have outpatient surgery	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	
If you need immediate medical attention	<u>Emergency</u> room care	10% <u>coinsurance</u> after In-network <u>deductible</u>		None
	<u>Emergency</u> medical transportation	10% <u>coinsurance</u> after In-network <u>deductible</u>		None
	<u>Urgent</u> care	10% <u>coinsurance</u>	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	Not covered	<u>Prauthorization</u> required or you pay 10% more
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	



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 need mental health, behavioral health or substance abuse services	Outpatient services	10% <u>coinsurance</u>	Not covered	Preauthorization required for Inpatient or you pay 10% more
	Inpatient services	10% <u>coinsurance</u>	Not covered	
If you are pregnant	Office visits	No charge; <u>deductible</u> waived	Not covered	Maternity care may include tests and services described elsewhere in SBC. Requires <u>preauthorization</u> for stays over 48 hrs (normal delivery)/96 hrs (caesarean) or you pay 10% more
	Prenatal Care	10% <u>coinsurance</u>	Not covered	
	Postnatal Care			
If you need help recovering or have other special health needs	Childbirth/delivery professional services	10% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	Not covered	
	<u>Home health care</u>	10% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required. 60 visits/yr
	<u>Rehabilitation services</u> — Inpatient	10% <u>coinsurance</u>	Not covered	60 days/yr with Skilled nursing care. <u>Preauthorization</u> required for Inpatient or you pay 10% more. 20 visits/yr each for Speech, Occupational & Physical therapies (<u>Preauthorization</u> required after 13 visits each for OT/PT/ST)
	Outpatient	10% <u>coinsurance</u>	Not covered	
	<u>Habilitation services</u> — Early Intervention	10% <u>coinsurance</u>	Not covered	To age 3 <u>Preauthorization</u> and visits limits based on services provided
	Developmental Delay	10% <u>coinsurance</u>	Not covered	
If your child needs dental or eye care	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not covered	60 days/yr with Inpatient rehab. <u>Preauthorization</u> required or you pay 10% more
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not covered	Please refer to plan document for items requiring <u>preauthorization</u>
	<u>Hospice services</u>	10% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required for Inpatient
	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 (Portuguès): De assistència em Portuguès, 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 <u>deductible</u>	\$4,000
■ Specialist <u>coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$4,000
Copayments	\$10
Coinsurance	\$600
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,670

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$4,000
■ Specialist <u>coinsurance</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>no charge</u>	

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$4,000
Copayments	\$50
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$4,070

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$4,000
■ Specialist <u>coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,400
Copayments	\$00
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,400