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 1-888-478-4752. For prescription drug coverage, go to www.express-scripts.com or by calling 1-866-544-9221. For mental health coverage, go to www.guidanceresources.com or by calling 1-866-615-3047.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$1,300** Individual*/**$2,600** Family coverage Non-network: **$2,600** Individual*/**$5,200** Family Does not apply to preventive services and preventive prescription drugs. *If 2 or more people are covered, family **deductible** must be satisfied before benefits are paid for any family member.	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. **$100** per year for inpatient Mental Health. There are no other specific **deductibles**.	You must pay all of the 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?	Network: **$3,000** Individual*/**$4,000** EE+Spouse or Child(ren)/**$6,000** Family Non-network: **$4,200** Individual/**$5,600** EE+Spouse or Child(ren)/**$8,400** Family *If 2 or more people are covered, individual **out-of-pocket limit** does not apply.	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?	**Premiums**, balance-billed charges, health care expenses this plan doesn't cover, and penalties for failure to obtain pre-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.	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. See **www.myuhc.com** or call 1-888-478-4752 for a list of participating providers.	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 network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network**. See the 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 can see the **specialist** you choose without permission from this plan.
Are there services this plan	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your

doesn't cover?		policy or plan document for additional information about **excluded services**.

- **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 network **providers** by charging you lower **deductibles** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network	Your Cost If You Use a Non-network	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	40% coinsurance after deductible	Virtual visits (Telehealth) – 20% co-ins per visit after deductible by a designated virtual network provider. No virtual coverage out-of-network.
	Specialist visit	20% coinsurance after deductible	40% coinsurance after deductible	————————none————————
	Other practitioner office visit	20% coinsurance for Chiropractic and Acupuncture services after deductible	40% coinsurance for Chiropractic and Acupuncture services after deductible	Limited to 20 visits for Chiropractic services and 8 visits for Acupuncture services per calendar year. Pre-notification required for certain services non-network or subject to a $300 reduction in benefits.
	Preventive care/screening/immunization	No Charge	No Charge	Applies to preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	————————none————————
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a Network	Your Cost If You Use a Non-network	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs (Includes Specialty drugs)	20% coinsurance after deductible	Member pays full cost and files a paper claim for reimbursement. Member will be reimbursed the discounted cost of the drug, minus the applicable member cost share.	Covers up to a 30-day supply (retail); 31-90 day supply (mail order or certain 90-day retail pharmacies). Long-term medications that can be purchased at retail or mail order but are purchased 30 days at a time instead will have an additional 50% fee starting on the third fill.
	Preferred brand drugs (Includes Specialty drugs)	20% coinsurance after deductible		
	Non-preferred brand drugs (Includes Specialty drugs)	20% coinsurance after deductible		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible	*20% coinsurance after deductible	*Network deductible applies. Pre-notification required for certain non-network services or subject to a $300 reduction in benefits
	Emergency medical transportation	20% coinsurance after deductible	*40% coinsurance after deductible	*Network deductible applies.
	Urgent care	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Pre-notification required for certain non-network services or subject to a $300 reduction in benefits.
	Physician/surgeon fee	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you have mental health, behavioral health, or substance abuse	Mental/Behavioral health outpatient services	20% coinsurance after deductible	Not Covered	Separate coverage provided by ComPsych
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	Not Covered	Separate coverage provided by ComPsych

Common Medical Event	Services You May Need	Your Cost If You Use a Network	Your Cost If You Use a Non-network	Limitations & Exceptions
needs More information about **mental health coverage** is available at www.guidanceresources.com	Substance use disorder outpatient services	20% coinsurance after deductible	Not Covered	Separate coverage provided by-ComPsych
	Substance use disorder inpatient services	20% coinsurance after deductible	Not Covered	Separate coverage provided by ComPsych
If you are pregnant	Prenatal and postnatal care	No charge for routine prenatal care. 20% coinsurance for other care	40% coinsurance for other care	Additional deductibles or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Pre-service notification required for non-network inpatient stays that exceed 48 hours for vaginal delivery/96 hours for cesarean section delivery or extended stay will be subject to a $300 reduction in benefits
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 40 visits per calendar year. Pre-notification required for certain non-network services or subject to a $300 reduction in benefits.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Depending on the type of therapy, there is a limit of 20-36 visits per calendar year. Pre-notification required for certain non-network services or subject to a $300 reduction in benefits.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Limits are combined with Rehabilitation Services limits listed above.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 90 days per calendar year, (limit is combined with IP Rehabilitation Services).Pre-notification required for certain non-network services or subject to a $300 reduction in benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Network	Your Cost If You Use a Non-network	Limitations & Exceptions
	Durable medical equipment (DME)	20% coinsurance after deductible	40% coinsurance after deductible	Pre-notification required for DME over $1,000 or no coverage. Limited to a single purchase of a type of DME (including repair/replacement) every 3 years.
	Hospice service	20% coinsurance after deductible	40% coinsurance after deductible	Inpatient pre-notification required for certain non-network services or subject to a $300 reduction in benefits.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Separate coverage by EyeMed
	Glasses	Not Covered	Not Covered	Separate coverage by EyeMed
	Dental check-up	Not Covered	Not Covered	Separate coverage by Cigna or MetLife

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/Child) (separate coverage by Cigna and MetLife)
- Glasses (separate coverage by EyeMed)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult) (separate coverage by EyeMed)
- 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
- Hearing aids – may be covered with limitations
- Infertility Treatment – may be covered with limitation

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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit http://www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit http://www.cciio.cms.gov .

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**

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 www.express-scripts.com.

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:///ciio.cms.gov/prgrams/consumer/capgrants/index.html.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-478-4752.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-888-478-4752.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-478-4752.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-478-4752.

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** $4,910
- **Patient pays** $2,630

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	$1,300
Copays	$0
Coinsurance	$1,180
Limits or exclusions	$150
Total	**$2,630**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,230
- **Patient pays** $2,170

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,300
Copays	$0
Coinsurance	$790
Limits or exclusions	$80
Total	**$2,170**

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 network **providers**. If the patient had received care from non-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**, 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 **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.