

 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, visit www.welcometouhc.com or by calling 1-800-782-3740. 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.healthcare.gov/sbc-glossary or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$0 out-of-Network: \$500 Individual / \$1,000 Family Per calendar year.	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.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and categories with a <u>copay</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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Network: \$2,500 Individual / \$5,000 Family out-of-Network: \$5,750 Individual / \$11,500 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> has been met.
What is not included in the out-of-pocket limit?	Premiums, <u>balance-billing</u> charges, (unless <u>balanced billing</u> is prohibited), health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a Network provider?	Yes. See www.welcometouhc.com or call 1-800-782-3740 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will 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.
Do you need a referral to see a specialist?	No.	You can see the <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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> per visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	Virtual visits (Telehealth) - No Charge by a Designated Virtual Network Provider. Cost share applies to any other Telehealth service based on <u>provider</u> type. If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery. Only applies to your designated PCP.
	<u>Specialist</u> visit	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
	<u>Preventive care/screening/immunization</u>	No Charge	40% <u>coinsurance</u>	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	40% <u>coinsurance</u>	<u>Preauthorization</u> required for <u>out-of-Network</u> for certain services or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	Designated Network: No Charge	40% <u>coinsurance</u>	For Designated Network Benefits, radiation services must be received from a Designated Diagnostic Provider. <u>Network Benefits</u> are services received from a <u>Network provider</u> that is not a Designated Diagnostic Provider and is covered at 50% <u>coinsurance</u> , <u>deductible</u> does not apply . <u>Preauthorization</u> required for <u>out-of-Network</u> or benefit reduces to 50% of allowed.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.welcometouhc.com	Tier 1 - Your Lowest-Cost Option	Deductible does not apply. Retail: \$10 copay Mail-Order: \$25 copay Specialty Drugs: \$10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order*: 90 day supply or *Preferred 90 Day Retail Network Pharmacy. Out-of-Network Pharmacy Drugs are Not Covered. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Certain preventive medications, zero cost share medications, and Tier 1 contraceptives are covered at No Charge. Growth Hormone Therapy : 30% coinsurance, Deductible does not apply.
	Tier 2 - Your Midrange-Cost Option	Deductible does not apply. Retail: \$45 copay Mail-Order: \$112.50 copay Specialty Drugs: \$150 copay	Not Covered	
	Tier 3 - Your Midrange-Cost Option	Deductible does not apply. Retail: \$85 copay Mail-Order: \$212.50 copay Specialty Drugs: \$500 copay	Not Covered	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	40% coinsurance	Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	No Charge	40% coinsurance	None
If you need immediate medical attention	Emergency room care	\$350 copay per visit, deductible does not apply	\$350 copay per visit, deductible does not apply	None
	Emergency medical transportation	No Charge	No Charge	None

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)	
	<u>Urgent care</u>	\$50 <u>copay</u> per visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	If you receive services in addition to <u>urgent care</u> visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> per admission, <u>deductible</u> does not apply	40% <u>coinsurance</u>	<u>Preauthorization</u> required for <u>out-of-Network</u> or benefit reduces to 50% of allowed.
	Physician/surgeon fees	No Charge	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	<u>Network</u> partial <u>hospitalization</u> /intensive outpatient treatment: No Charge . <u>Preauthorization</u> required for certain services for <u>out-of-Network</u> or benefit reduces to 50% of allowed.
	Inpatient services	\$500 <u>copay</u> per admission, <u>deductible</u> does not apply	40% <u>coinsurance</u>	<u>Preauthorization</u> required for <u>out-of-Network</u> or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>copayment</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply.
	Childbirth/delivery professional services	No Charge	40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery facility services	\$500 <u>copay</u> per admission, <u>deductible</u> does not apply	40% <u>coinsurance</u>	Additional <u>copays</u> , <u>deductibles</u> , <u>coinsurance</u> may apply. Inpatient <u>preauthorization</u> apply for <u>out-of-Network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed.
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	40% <u>coinsurance</u>	Limited to 60 visits per calendar year. <u>Preauthorization</u> required for <u>out-of-Network</u> or benefit reduces to 50% of allowed.
	<u>Rehabilitation services</u>	\$15 <u>copay</u> per outpatient visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	Limits per calendar year: Physical, Speech Occupational: 20 visits each. Pulmonary unlimited. Cardiac 36 visits.

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)	
	<u>Habilitation services</u>	\$15 <u>copay</u> per outpatient visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	Services provided under and limits are combined with <u>Rehabilitation services</u> above. Cost share applies for outpatient services only. <u>Preauthorization</u> required for out-of-Network inpatient services or benefit to 50% of allowed.
	<u>Skilled nursing care</u>	\$500 <u>copay</u> per admission, <u>deductible</u> does not apply	40% <u>coinsurance</u>	<u>Preauthorization</u> required for <u>out-of-Network</u> or benefit reduces to 50% of allowed. Skilled nursing is limited to 120 days per calendar year (combined with Inpatient Rehabilitation).
	<u>Durable medical equipment</u>	No Charge	40% <u>coinsurance</u>	Repair or replacement of DME or orthotics is limited to its necessity due to a growing child's functional need. <u>Preauthorization</u> required for <u>out-of-Network Durable medical equipment</u> over \$1,000 or no coverage.
	<u>Hospice services</u>	No Charge	40% <u>coinsurance</u>	<u>Preauthorization</u> required for <u>out-of-Network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Eye exam.
	Children's glasses	Not Covered	Not Covered	No coverage for Glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)				
• Acupuncture	• Bariatric surgery	• Cosmetic surgery	• Dental care (Adult/Child)	• Glasses
• Infertility treatment	• Long-term care	• Non-emergency care when traveling outside the 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 per calendar year
- Hearing aids-\$2,500/calendar year

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: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration. You may also contact us at 1-800-782-3740. 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 on how 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: 1-800-782-3740; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Florida Department of Financial Services at 1-877-693-5236 or www.myfloridacfo.com.

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 1-800-782-3740.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-782-3740.

Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwijigo holne' 1-800-782-3740.

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 \$ 0
- Specialist copayment \$25
- Hospital (facility) copayment \$500
- Other coinsurance 0%

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:	
<i>Cost Sharing</i>	
<u>Deductible</u>	\$0
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$560

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$ 0
- Specialist copayment \$25
- Hospital (facility) copayment \$500
- Other coinsurance 0%

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:	
<i>Cost Sharing</i>	
<u>Deductible</u>	\$0
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,000

Mia's Simple Fracture

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

- The plan's overall deductible \$ 0
- Specialist copayment \$25
- Hospital (facility) copayment \$500
- Other coinsurance 0%

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:	
<i>Cost Sharing</i>	
<u>Deductible</u>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$400

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