
 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, [insert contact information]. 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 <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-new.pdf> or call 1-844-234-7925 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">In-Network</a> : \$1,650 individual / \$3,300 family. <a href="#">Out-of-Network</a> : \$2,500 individual / \$5,000 family.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">deductible</a> must be met before this <a href="#">plan</a> begins to pay.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<a href="#">In-Network</a> : \$2,500 individual / \$5,000 family. <a href="#">Out-of-network</a> : \$5,000 individual / \$10,000 family. Includes <a href="#">prescription drug</a> expenses.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover and pre-notification for services. Reimbursement received from copay assistance.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> . The cost of the drugs reimbursed by the manufacturer will not be applied towards satisfying your <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. For a list of <a href="#">network providers</a> , see <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-844-234-7925.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Virtual visit – <a href="#">In-network</a> 10% <a href="#">coinsurance</a> after deductible by a Designated Virtual Network Provider. No coverage for <a href="#">out-of-network</a> . For <a href="#">additional services</a> , <a href="#">additional copays</a> , <a href="#">deductibles</a> , or <a href="#">coinsurance</a> may apply. Convenient Care visit - <a href="#">In-network</a> 10% <a href="#">coinsurance</a> after deductible. <a href="#">Out-of-network</a> 30% <a href="#">coinsurance</a> after deductible.
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% <a href="#">coinsurance</a> for Mammograms, PAPS: otherwise not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what the plan will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for out-of-network sleep studies or a 20% penalty applies.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for out-of-network providers or a 20% penalty 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)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a></p>	Generic drugs	20% <a href="#">coinsurance</a> Retail: Minimum \$10 <a href="#">copay</a> , Maximum \$75 <a href="#">copay</a>  Retail Maintenance and Mail Order: Minimum \$20 co-pay, Maximum \$150 <a href="#">copay</a>	Retail: 50% after deductible Mail Order: not covered	Retail Non-Maintenance: Up to a 30-day supply. Retail Maintenance New Prescription: Up to three fills of a 30-day supply.  Retail and Mail Order Maintenance: Up to a 90-day supply. After three 30-day fills of a maintenance medication, if you do not fill for a 90-day supply, you will be responsible for the full cost of the medication. This cost will not apply towards your deductible out-of-pocket maximum.
	Preferred brand drugs	20% <a href="#">coinsurance</a> Retail: Minimum \$25 <a href="#">copay</a> , Maximum \$150 <a href="#">copay</a>  Retail Maintenance and Mail Order: Minimum \$60 <a href="#">copay</a> , Maximum \$300 <a href="#">copay</a>	Retail: 50% after deductible Mail Order: not covered	Your plan uses a preferred drug list which identifies the status of covered drugs.  Some drugs may require <a href="#">preauthorization</a> . If the necessary <a href="#">preauthorization</a> is not obtained, the drug may not be covered.
	Non-preferred brand drugs	20% <a href="#">coinsurance</a> Retail: Minimum \$40 <a href="#">copay</a> , Maximum of \$250 <a href="#">copay</a>  Retail Maintenance and Mail Order: Minimum \$100 <a href="#">copay</a> , Maximum \$500 <a href="#">copay</a>	Retail: 50% after deductible Mail Order: not covered	Certain items identified by your <a href="#">plan</a> as <a href="#">preventive care</a> are covered in full and not subject to the co-pay amounts indicated.
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a> Retail or Mail Order 30-Day Supply: Minimum \$25 <a href="#">copay</a> , Maximum \$150 <a href="#">copay</a>  Retail or Mail Order 90-Day Supply Minimum \$60 <a href="#">copay</a> , Maximum \$300 <a href="#">copay</a>	Retail: 50% after deductible Mail Order: not covered	Please see “Important Questions” regarding the plan’s out-of-pocket limit.

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for out-of-network providers or a 20% penalty applies.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for out-of-network providers or a 20% penalty applies.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Inpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for out-of-network providers or a 20% penalty applies.
<b>If you are pregnant</b>	Office visits	10% <a href="#">coinsurance</a> initial visit only	30% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for out-of-network providers or a 20% penalty applies. <a href="#">Preauthorization</a> is also required for stays exceeding standard delivery timeframes or a 20% penalty 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 need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Unlimited <a href="#">in-network</a> . 60 days per calendar year <a href="#">out-of-network</a> reduced by any in-network days. <a href="#">Preauthorization</a> is required for out-of-network providers or a 20% penalty applies.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	180 days per calendar year <a href="#">in-network</a> and <a href="#">out-of-network</a> combined. Includes physical, speech and occupational therapy; cardiac, cognitive and pulmonary rehabilitation. <a href="#">Preauthorization</a> is required for out-of-network providers or a 20% penalty applies.
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	None
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	60 days per calendar year <a href="#">in-network</a> and <a href="#">out-of-network</a> combined. <a href="#">Preauthorization</a> is required for out-of-network providers or a 20% penalty applies.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for DME devices that cost more than \$1000 per device (purchase or cumulative rental) and for <a href="#">out-of-network</a> providers or a 20% penalty applies.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for out-of-network providers or a 20% penalty applies.
If your child needs dental or eye care	Children's eye exam	No Charge	Covered up to \$45	For a list of providers visit <a href="http://www.vsp.com">www.vsp.com</a> or call 1-800-877-7195.
	Children's glasses	No charge for lenses. Glasses covered up to \$200 allowance	Single Vision Lenses covered up to \$30, Bifocals covered up to \$50. Frames covered up to \$70	Exams and lenses every 12 months. Frames every 12 months.
	Children's dental check-up	Not Covered	Not Covered	None

## 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](#).)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric surgery, prior authorization required
- Chiropractic care 25 day limit covered [in-network](#) only
- Eye care and glasses (Children) (See Page 5)
- Hearing aids \$750 maximum every 36 months, No maximum for children up to age 18
- Infertility treatment \$20,000 lifetime maximum In and out of network combined. Lifetime maximum does not apply to diagnostic and planning services.
- Routine eye care (Adult). No Charge [in-network](#), covered up to \$45 [out-of-network](#)
- Routine foot care covered for services associated with foot care for diabetes and peripheral vascular disease

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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](http://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, contact: UnitedHealthCare Customer Service at 1-844-234-7925. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact: Tennessee Department of Commerce and Insurance at 1-800-342-4029.

**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 the 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](#).

————— *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](#) \$1600
- [Specialist coinsurance](#) 10%
- [Hospital \(facility\) coinsurance](#) 10%
- [Other coinsurance](#) 20%

**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*)

<b>Total Example Cost</b>	<b>\$12800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1600
Copayments	\$0
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2500</b>

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

- The [plan's](#) overall [deductible](#) \$1600
- [Specialist coinsurance](#) 10%
- [Hospital \(facility\) coinsurance](#) 10%
- [Other coinsurance](#) 20%

**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*)

<b>Total Example Cost</b>	<b>\$7400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1600
Copayments	\$0
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1600</b>

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

- The [plan's](#) overall [deductible](#) \$1600
- [Specialist coinsurance](#) 10%
- [Hospital \(facility\) coinsurance](#) 10%
- [Other coinsurance](#) 20%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1600
Copayments	\$0
Coinsurance	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1630</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.