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 1-800-782-3158. 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?	Designated Network and Network: $2,500 Individual / $5,000 Family out-of-Network: $5,000 Individual / $10,000 Family Per calendar year.	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. Preventive care and categories with a copay are 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 www.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?	Designated Network and Network: $8,550 Individual / $17,100 Family out-of-Network: $10,000 Individual / $20,000 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 has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	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 www.welcometouhc.com or call 1-800-782-3158 for a list of network providers.	You pay the least if you use a provider in the Designated network. You pay more if you use a provider in the network. You will 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 can see the 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
		Designated Network Provider (You will pay the least)	Network Provider	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	$10 copay per visit, deductible does not apply	$10 copay per visit, deductible does not apply	40% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery. Virtual visits (Telehealth) - No Charge by a Designated Virtual Network Provider. Children under age 19: No Charge.
	Specialist visit	$40 copay per visit, deductible does not apply	$80 copay per visit, deductible does not apply	40% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening /immunizatio-n	No Charge	No Charge	40% coinsurance	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: $40 copay per service, deductible does not apply X-ray: $50 copay per service, deductible does not apply	Lab: $60 copay per service, deductible does not apply X-ray: $50 copay per service, deductible does not apply	40% coinsurance	Preauthorization required for out-of-Network for certain services or benefit reduces to 50% of allowed. For Designated Network Benefits, lab services must be received by a Designated Diagnostic Provider. Network Benefits are lab services received from a Network provider that is not a Designated Diagnostic Provider and is covered at $60 copay per service, deductible does not apply .
	Imaging (CT/PET scans, MRIs)	$150 copay per service, deductible does not apply	$300 copay per service, deductible does not apply	40% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Designated Network Provider (You will pay the least)	Network Provider	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: $20 copay Specialty Drugs** : $10 copay	Deductible does not apply. Retail: $10 copay Mail-Order: $20 copay Specialty Drugs** : $10 copay	Deductible does not apply. Retail: $10 copay Specialty Drugs: $10 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order*: Up to a 90 day supply or *Preferred 90 Day Retail Network Pharmacy. If you use an out-of-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. **Your cost shown is for a Preferred Specialty Network Pharmacy. Non-Preferred Specialty Network Pharmacy: Copay is 2 times the Preferred Specialty Network Pharmacy Copay or the coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier. 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. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Prescription drug List (PDL): Essential . Network: Standard Select - Walgreens. . You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Certain preventive medications and Tier 1 contraceptives are covered at No Charge. If a dispensed drug has a chemically equivalent drug, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied.
	Tier 2 - Your Midrange-Cost Option	Deductible does not apply. Retail: $40 copay Mail-Order: $80 copay Specialty Drugs** : $40 copay	Deductible does not apply. Retail: $40 copay Mail-Order: $80 copay Specialty Drugs** : $40 copay	Deductible does not apply. Retail: $40 copay Specialty Drugs: $40 copay	
	Tier 3 - Your Midrange-Cost Option	Deductible does not apply. Retail: $105 copay Mail-Order: $210 copay Specialty Drugs** : $150 copay	Deductible does not apply. Retail: $105 copay Mail-Order: $210 copay Specialty Drugs** : $150 copay	Deductible does not apply. Retail: $105 copay Specialty Drugs: $150 copay	
	Tier 4 - Additional High-Cost Options	Deductible does not apply. Retail: $250 copay Mail-Order: $500 copay Specialty Drugs** : $500 copay	Deductible does not apply. Retail: $250 copay Mail-Order: $500 copay Specialty Drugs** : $500 copay	Deductible does not apply. Retail: $250 copay Specialty Drugs: $500 copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center: 20% coinsurance Hospital: 40% coinsurance	Ambulatory Surg Center: 20% coinsurance Hospital: 40% coinsurance	40% coinsurance	Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Designated Network Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
	Physician/ surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	40% coinsurance	None
	Emergency medical transportati-on	20% coinsurance	20% coinsurance	20% coinsurance	None
	Urgent care	$25 copay per visit, deductible does not apply	$25 copay per visit, deductible does not apply	40% coinsurance	If you receive services in addition to urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	40% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Physician/ surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay per visit, deductible does not apply	$40 copay per visit, deductible does not apply	No Charge	Network partial hospitalization /intensive outpatient treatment: 20% coinsurance Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.
	Inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	No Charge	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, deductibles, or coinsurance may apply.
	Childbirth/ delivery professional services	20% coinsurance	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Designated Network Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
	Childbirth/ delivery facility services	20% coinsurance	20% coinsurance	40% coinsurance	Inpatient preauthorization apply for out-of-Network 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	Home health care	20% coinsurance	20% coinsurance	40% coinsurance	Limited to 100 visits per calendar year. Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Rehabilitation services	$10 copay per outpatient visit, deductible does not apply	$10 copay per outpatient visit, deductible does not apply	40% coinsurance	Limits per calendar year: Physical and Occupational: 30 visits combined; Speech: 30 visits; Pulmonary and Cardiac: Unlimited.
	Habilitation services	$10 copay per outpatient visit, deductible does not apply	$10 copay per outpatient visit, deductible does not apply	40% coinsurance	Limits per calendar year: Physical and Occupational: 30 visits combined; Speech: 30 visits. Cost share applies for outpatient services only. Preauthorization required for out-of-Network inpatient services or benefit to 50% of allowed.
	Skilled nursing care	20% coinsurance	20% coinsurance	40% coinsurance	Skilled Nursing Facility is limited to 100 days per calendar year (combined with Inpatient Rehabilitation) . Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Durable medical equipment	20% coinsurance	20% coinsurance	40% coinsurance	Preauthorization required for out-of-Network Durable medical equipment over $1,000 or no coverage.
	Hospice services	20% coinsurance	20% coinsurance	40% coinsurance	Preauthorization required for out-of-Network 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	$10 copay per visit, deductible does not apply	$10 copay per visit, deductible does not apply	50% coinsurance	One exam every 12 months.
	Children's glasses	50% coinsurance, deductible does not apply	50% coinsurance, deductible does not apply	50% coinsurance	One pair every 12 months.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Designated Network Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	No Charge	No Charge	No Charge	Cleanings covered 2 times per 12 months.

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 (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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-30 visits per calendar year
- Hearing aids-$1,500 every 24 months
- Private-duty nursing - 2 visits/calendar year
- Routine eye care (Adult)-1 exam/12 months

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 1-800-782-3158 . 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: 1-800-782-3158 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Virginia Bureau of Insurance at 1-877-310-6560 or www.scc.virginia.gov/boi.

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 1-800-782-3158 .
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3158 .
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-782-3158 .
Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-800-782-3158 .

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** **$ 2,500**
- **Specialist copayment** **$80**
- **Hospital (facility) coinsurance** **20%**
- **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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$400
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,360**

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

- **The plan's overall deductible** **$ 2,500**
- **Specialist copayment** **$80**
- **Hospital (facility) coinsurance** **20%**
- **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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,200**

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

- **The plan's overall deductible** **$ 2,500**
- **Specialist copayment** **$80**
- **Hospital (facility) coinsurance** **20%**
- **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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,100
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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