**Summary of Benefits and Coverage:** What This Plan Covers & What it Costs

**Coverage Period:** 01/01/2017 – 12/31/2017

**Coverage for:** Employee & Family

**Plan Type:** EP1

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 welcometouhc.com or by calling 1-800-382-2599.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the chart starting on page 2 for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Network: $1,500 Individual / $3,000 Family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premium, balance-billed charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of network providers, see myuhc.com or call 1-800-382-2599.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-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.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-800-382-2599 or visit us at welcometouhc.com. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.
Summary of Benefits and Coverage: What This Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>WU Direct: $15 copay per visit Other Network provider: $25 copay per visit</td>
<td>Not Covered</td>
<td>Virtual visits (Telehealth) – No Charge deductible by a designated virtual network provider.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>WU Direct: $25 copay per visit Other Network provider: $50 copay per visit</td>
<td>Not Covered</td>
<td>If you receive services in addition to office visit, additional copays, deductibles, or co-Ins may apply.</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$50 copay per visit</td>
<td>Not Covered</td>
<td>Cost share applies only to manipulative (chiropractic) services, which are limited to 60 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Includes preventive health services specified in the health care reform law. No coverage non-network.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% co-ins</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT / PET scans, MRIs)</td>
<td>20% co-ins</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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<td>Your Cost If You Use a Non-Network Provider</td>
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<td>----------------------</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 – Generic Drugs</td>
<td>$10 copay/prescription (retail) $25 copay/prescription (mail-order) Copay for generic drugs used to treat diabetes and heart disease drugs for high cholesterol and hypertension only: $4 retail; $10 mail-order</td>
<td>25% co-insurance $40 min. - $80 max. (retail) $100 min. - $200 max. (mail-order)</td>
<td>Prescription drug coverage is provided under a separate plan administered by Express Scripts. Covers up to a 30-day supply through retail; up to a 90-day supply through mail-order. Prescription drug plan out-of-pocket limit: $2,500 individual/$5,000 family</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$150 copay per visit</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician / surgeon fees</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$150 copay per visit</td>
<td>$150 copay per visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No Charge</td>
<td>No Charge</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$35 copay per visit</td>
<td>Not Covered</td>
<td>If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$300 copay per inpatient stay</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>
# Summary of Benefits and Coverage: What This Plan Covers & What it Costs

**Coverage for:** Employee & Family  
**Plan Type:** EP1

<table>
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<th>Your Cost If You Use a Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Physician / surgeon fees</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>
| | Mental / Behavioral health outpatient services | WU Direct: $25 copay per visit  
Other Network provider: $50 copay per visit | Not Covered | None |
| | Mental / Behavioral health inpatient services | $300 copay per inpatient stay | Not Covered | None |
| | Substance use disorder outpatient services | WU Direct: $25 copay per visit  
Other Network provider: $50 copay per visit | Not Covered | None |
| | Substance use disorder inpatient services | $300 copay per inpatient stay | Not Covered | None |
| If you are pregnant | Prenatal and postnatal care | No Charge | Not Covered | Additional copays, deductibles, or coins may apply depending on services rendered. |
| | Delivery and all inpatient services | $300 copay per inpatient stay | Not Covered | Your cost for inpatient services only. Delivery Services cost share is reflected in "Physician/surgeon fees" above. |
| If you need help recovering or have other special health | Home health care | No Charge | Not Covered | Limited to 100 visits per calendar year. |
## Summary of Benefits and Coverage: What This Plan Covers & What it Costs

### Coverage for: Employee & Family  
**Plan Type:** EP1  

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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>WU Direct: $25 copay per outpatient visit</td>
<td>Not Covered</td>
<td>Limited to 60 visits per therapy, per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Other Network provider: $50 copay per outpatient visit</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitative services</td>
<td>WU Direct: $25 copay per outpatient visit</td>
<td>Not Covered</td>
<td>Limits are combined with Rehabilitation Services limits listed above.</td>
</tr>
<tr>
<td></td>
<td>Other Network provider: $50 copay per outpatient visit</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$300 copay per inpatient stay</td>
<td>Not Covered</td>
<td>Nursing limited to 70 days per calendar year. Inpatient Rehabilitation services are limited to 60 days per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% co-ins</td>
<td>Not Covered</td>
<td>Covers 1 per type of DME (including repair/replacement) every 3 years.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Limited to 180 days per calendar year.</td>
</tr>
</tbody>
</table>

### If your child needs dental or eye care

If your child needs dental or eye care:

<table>
<thead>
<tr>
<th></th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>No coverage for Eye Exams.</td>
</tr>
<tr>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>No coverage for glasses.</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>No coverage for dental check-up.</td>
</tr>
</tbody>
</table>

### 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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult/Child)
- Glasses (Adult/Child)
- Hearing aids
- 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** (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)
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 www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-382-2599.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-382-2599.
Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-382-2599.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-382-2599.
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To see examples of how this plan might cover costs for a sample medical situation, see the next page.---------------------------
### Summary of Benefits and Coverage:
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#### 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.

---

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,940
- **Patient pays:** $600

**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: $0
- Copays: $300
- Coinsurance: $100
- Limits or exclusions: $200

**Total:** $600

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,900
- **Patient pays:** $1,500

**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: $0
- Copays: $300
- Coinsurance: $1,100
- Limits or exclusions: $100

**Total:** $1,500

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*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.
Summary of Benefits and Coverage: What This Plan Covers & What it Costs

What are some of the assumptions behind the Coverage Examples?
- Costs don’t include premiums.
- Sample care costs are based on national averages supplied to 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 in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?
For each treatment situation, the Coverage Example helps you see how deductibles, copayments, 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 copayments, 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.

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