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 https://hrportal.ehr.com/travelers/ or call 1-800-441-4378. 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.cms.gov or call 1-800-441-4378 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$750** Individual / **$1,500** Family Non-Network: **$1,500** Individual / **$3,000** 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 primary care services with 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. A copayment or coinsurance may apply. This plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No, there are no other deductibles.	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.
What is the out-of-pocket limit for this plan?	**Medical** Network provider: **$3,800** Individual / **$7,600** Family Out-of-network provider: **$7,600** Individual / **$15,200** Family per calendar year. This plan has a separate pharmacy Out of Pocket Maximum of **$2,800**/individual or **$5,600**/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. The Medical and Prescription Drug out-of-pocket limits are separate.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services. Drug coinsurance, and certain specialty pharmacy drugs eligible for the copay assistance program.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. The cost of drugs eligible for the copay assistance program (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-866-679-0947 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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
		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	$35 copay/visit deductible does not apply	30% coinsurance	Virtual visit - In network $10 copay per visit by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copayments, deductibles, or coinsurance may apply
	Specialist visit	$45 copay/visit deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	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)	10% coinsurance; deductible does not apply for blood work.	30% coinsurance	Prior Authorization required for out of network Sleep Studies or penalty of $500 applies.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Prior Authorization required for out of network or penalty of $500 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 drugs to treat your illness or condition **More information about prescription drug coverage is available at** www.cvs.com	Generic drugs Retail (30-day supply) Retail/Mail 90-day supply*	$12 Copay $24 Copay	See Limitations & Exceptions.	If you fill a prescription at an out-of-network pharmacy but had access to a network pharmacy, you will be reimbursed for the negotiated pharmacy cost minus the applicable in-network coinsurance. If you did not have access to a network pharmacy, the in-network coinsurance will apply. Specialty drugs must be filled by CVS Specialty. Participation in the PrudentRx Copay Program will determine what you will pay. Pre-authorization is required for certain drugs. For infertility drugs, there is no minimum or maximum copayment and coinsurance does not apply to the out-of-pocket maximum. *90-day supply: CVS retail or CVS Caremark mail order pharmacies ONLY
	Preferred brand drugs Retail (30-day supply) Retail/Mail 90-day supply*	20% Coinsurance $50 min, $175 max $100 min, $350 max		
	Non-preferred brand drugs Retail (30-day supply) Retail/Mail 90-day supply*	40% Coinsurance $50 min, $175 max $100 min, $350 max		
	Specialty drugs (30-day supply)	0% Coinsurance if participating with PrudentRx; 30% Coinsurance if not participating with PrudentRx		
	Infertility drugs	50% Coinsurance		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Employee initiated pre-authorization required for certain surgical procedures out of Network or coverage reduced by $500.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$200 copay/visit deductible does not apply	Covered as In-Network	If admitted, the ER copay is waived.

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)	
	Emergency medical transportation	10% coinsurance	Covered as In-Network	Prior Authorization required for Non-emergent ambulance out of network or penalty of $500 applies.
	Urgent care	$45 copay/visit deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Prior Authorization required for out of network or penalty of $500 applies.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit deductible does not apply	30% coinsurance	Prior Authorization required for out of network Applied Behavioral Analysis (ABA) and certain outpatient services or penalty of $500 applies.
	Inpatient services	10% coinsurance	30% coinsurance	Prior Authorization required for out of network or penalty of $500 applies.

If you are pregnant	Office visits	$45 copay/initial visit only deductible does not apply to initial visit.	30% coinsurance	Routine pre-natal care covered at no charge after initial Specialist visit. Prior Authorization required for out of network for inpatient stays that exceed normal 48 hours for vaginal delivery or 96 hours for cesarean or penalty of $500 applies. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Health care professional charges for deliveries in the home, childbirth classes, services for or related to surrogate pregnancy not covered.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	60 visits per calendar year. Prior Authorization required for out of network or penalty of $500 applies.
	Rehabilitation services	$35 copay/visit deductible does not apply	30% coinsurance	Physical and Occupational Therapy combined 60 visits. Speech, Aural, Cardiac and Pulmonary Therapy 60 visits per calendar year each. Vision Therapy 30 visits per calendar year. Prior Authorization required for out of network or penalty of $500 applies.
	Habilitation services	$35 copay/visit deductible does not apply	30% coinsurance	Covered same as Rehabilitation Services.
	Skilled nursing care	10% coinsurance	30% coinsurance	60 days per calendar year. Prior Authorization required for out of network or penalty of $500 applies.
	Durable medical equipment	10% coinsurance	30% coinsurance	Prior Authorization required for out of network purchases of $1,000 or more or penalty of $500 applies.
	Hospice services	10% coinsurance	30% coinsurance	180 days per lifetime. Prior Authorization required for out of network or penalty of $500 applies.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	1 routine vision exam, in Doctor's office, including refraction, per calendar year.
	Children's glasses	Not covered	Not covered	Not Covered
	Children's dental check-up	Not covered	Not covered	Not Covered

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.)

- Blood pressure monitoring devices
- Child dental check-up
- Child vision glasses
- Cosmetic Surgery
- Hearing aids for adults (age 19 and older)
- Long-term care
- Modifications to your home, vehicle and/or the workplace, including vehicle ramps and lifts
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Reversal of voluntary sterilization
- Weight loss programs

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

- Acupuncture (20 visits/calendar year)
- Adult routine vision exam (i.e. refraction) (in network only and certain restrictions apply)
- Bariatric Surgery (in network only and certain restrictions apply)
- Chiropractic care (subject to copay and 20 visit limit per calendar year)
- Dental Care (for accident or medical treatment only)
- Hearing aids for children under age 19 (limitations apply)
- Infertility treatment (certain restrictions apply) $20,000/Lifetime
- Routine foot care

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://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/ 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: 1-866-679-0947 or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-679-0947.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-679-0947.
Chinese (**中文**): **如果需要中文的帮助**，请拨打这个号码 1-866-679-0947.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-679-0947.

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	$750
■ Specialist copayment	$50
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal 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	$750
Copayments	$50
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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

■ The plan's overall deductible	$750
■ Specialist copayment	$50
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	$500
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

■ The plan's overall deductible	$750
■ Specialist copayment	$50
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	$750
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

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

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20211

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 **(Korean)** 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

ملحوظة: إذا كنت تتحدث اللغة العربية **(Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل ملخص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリー
ダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره ذیل رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदद आप **ह दी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नन:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सचीबद्ध टोल फ्री नबरां पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការគ្របដណ្តប់ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).