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 us at mylowesbenefits.com or by calling 1-844-475-6937. 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.healthcare.gov/sbc-glossary/ or call 1-855-892-2401 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copayment are covered before you meet your deductible.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing. 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?	Network Providers: $9,100 individual / $18,200 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, health care this plan doesn't cover, charges exceeding allowed amount, and allowed amounts exceeding plan limits.	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.flexwork.uhc.com or call 1-855-892-2401 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	$25 copay/visit	Not Covered	4 office visit limit/year, combined sickness, injury, mental health, substance abuse services, pregnancy or specialist visits. Members can also receive limited virtual care at $0 copay by enrolling in and using HealthiestYou Telehealth Services consultations.
	Specialist visit	$50 copay/visit	Not Covered	
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive 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 you need are preventive, then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.flexwork.uhc.com	Generic drugs	Retail: $15 copay Mail-Order: 2.5x copay - $37.50 copay	Not Covered	Retail: Up to a 31-day supply. Mail-Order: Up to a 90-day supply. One retail copay applies per 31-day retail prescription. You may need to obtain certain drugs including specialty drugs from a pharmacy designated by. This plan covers certain preventive prescription drugs specified in the health care reform law without cost-sharing. See a list of covered preventive drugs at: www.flexwork.uhc.com.
	Brand name drugs	Retail: 50% coinsurance Mail-Order: 50% coinsurance	Not Covered	

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)	
				Members also receive an Optum Perks™ pharmacy discount card that can help save on most FDA-approved medications.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	Not Covered
	Physician/surgeon fees	Not Covered	Not Covered	
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	Not Covered
	Emergency medical transportation	Not Covered	Not Covered	None
	Urgent care	$150 copay/visit includes facility and physician fees.	Not Covered	2 visit limit/year. Lab, x-rays, diagnostic testing and imaging are not included in benefit for urgent care and are not covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	Not Covered
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Primary care: $25 copay/visit Specialist: $50 copay/visit	Not Covered	4 office visit limit/year, combined sickness, injury, mental health, substance abuse services, pregnancy or specialist visits. Members can also receive limited behavioral health care via the 24/7 Employee Assistance Support Line and HealthiestYou Telehealth Services unlimited number of consultations at $0 copay.
	Inpatient services	Not Covered	Not Covered	Not Covered
If you are pregnant	Office visits	Primary care: $25 copay/visit	Not Covered	4 office visit limit/year, combined sickness, injury, mental health, substance abuse services, pregnancy or specialist visits. Cost sharing does not apply for Health Care

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)	
		Specialist: $50 copay/visit		Reform preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Not Covered	Not Covered	Not Covered
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	None
	Rehabilitation services	Not Covered	Not Covered	None
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	Not Covered	Not Covered	None
	Durable medical equipment	Not Covered	Not Covered	None
	Hospice services	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	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.)

- Acupuncture
- Bariatric surgery
- Childbirth/Delivery
- Children's eye exam
- Children's dental check-up
- Children's glasses
- Chiropractor
- Cosmetic surgery
- Dental care (adult)
- Diagnostic tests and Imaging
- Durable medical equipment
- Emergency room care
- Emergency medical transportation
- Habilitation services
- Hearing aids
- Home health care
- Hospice services
- Hospital Stay
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Outpatient Surgery
- Private-duty nursing
- Rehabilitation services
- Routine eye care (adult)
- Routine foot care
- Skilled nursing care, and
- Weight-loss programs

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

None

* For more information about limitations and exceptions, see the plan or policy document at www.flexwork.uhc.com.

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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: UnitedHealthcare FlexWork® at 1-855-892-2401, or the Department of Labor's 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? No

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 1-800-291-2634.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-291-2634.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-291-2634.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-291-2634.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

* For more information about limitations and exceptions, see the plan or policy document at www.flexwork.uhc.com.

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	$50
Hospital (facility) copayment	$0
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:	
Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11,000
The total Peg would pay is	**$11,060**

In this example, because this condition is not covered under this plan, Peg would pay 100% of the total cost, less the cost of certain routine prenatal care and covered Specialist office visits (see "If you are pregnant" above.)

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	$50
Hospital (facility) copayment	$0
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:	
Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Joe would pay is	**$1,000**

In this example, because some services for this condition are not covered under this plan, Joe would still be responsible for a portion of his medical costs.

Mia's Simple Fracture

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

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) copayment	$0
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:	
Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,600
The total Mia would pay is	**$2,700**

In this example, because this condition is not covered under this plan, Mia would pay 100% of the total cost, less the cost of covered Specialist office visits).

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