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, go to **mySHSBenefits.com** or call **833-935-3328**. 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://healthcare.gov/SBC-GLOSSARY/** or call **833-935-3328** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$900** individual / **$1,800** individual +1 / **$2,250** family in-network; **$1,350** individual / **$2,700** individual +1 / **$3,375** family out-of-network (includes prescription drugs, Mental Health and Substance Abuse). The Company contributes **$400** individual or **$800** individual plus spouse or domestic partner to your HRA. The maximum HRA balance that can roll over from year to year is $4,000.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. In-network and out-of-network deductibles are separate. Expenses applied to the in-network deductible are not applied to the out-of-network deductible. Expenses applied to the out-of-network deductible are not applied to the in-network deductible. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes, preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. 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 https://healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other specific 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?	**$3,700** individual / **$7,400** individual +1 / **$10,000** family in-network; **$4,700** individual / **$9,400** individual +1 / **$14,000** family out-of-network; include deductible and copay.	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. In-network and out-of-network out-of-pocket limits are separate. Expenses applied to the in-network limit are not applied to the out-of-network limit. Expenses applied to the out-of-network limit are not applied to the in-network limit.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, prescription drugs (separate limit applies), services deemed not medically necessary, penalties for non-compliance, charges over the maximum allowed amount, balance-billed charges, and health care this plan option doesn't cover.	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. For a list of preferred providers, see **myuhc.com** or call **866-238-2637**.	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

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
		In-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	15% coinsurance	35% coinsurance	Coinsurance applied to deductibles and annual out-of-pocket limits. No cross-application of deductibles and out-of-pocket maximum between in-network and out-of-network benefits.
	Specialist visit	15% coinsurance	35% coinsurance	Coinsurance applied to deductibles and annual out-of-pocket limits. No cross-application of deductibles and out-of-pocket maximum between in-network and out-of-network benefits.
	Preventive care/screening/ immunization	No charge	35% coinsurance	Subject to federal health care reform guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	35% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	35% coinsurance	Preauthorization may be required; limitations may apply.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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 caremark.com or cvsspeciality.com	Generic drugs	10% coinsurance (minimum of $5 at retail or $10 for mail order)	You are reimbursed 90% of in-network cost after your submitted claim is approved.	Up to 30-day supply at retail (limit one refill, then mandatory mail order); 90-day supply for mail order. $2,300 individual / $3,500 family out-of-pocket maximum. Certain preventive medications are covered at 100%.
	Preferred brand drugs	30% coinsurance (minimum $20 at retail or $40 for mail order)	You are reimbursed 70% of in-network cost after your submitted claim is approved.	Up to 30-day supply at retail (limit one refill, then mandatory mail order); 90-day supply for mail order. $2,300 individual / $3,500 family out-of-pocket maximum.
	Non-preferred brand drugs	45% coinsurance (minimum $35 at retail or $70 for mail order)	You are reimbursed 55% of in-network cost after your submitted claim is approved.	Up to 30-day supply at retail (limit one refill, then mandatory mail order); 90-day supply for mail order. $2,300 individual / $3,500 family out-of-pocket maximum.
	Specialty drugs	Check with plan	Check with plan	For eligible drugs only. $2,300 individual / $3,500 family out-of-pocket maximum. Limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	35% coinsurance	None
	Physician/surgeon fees	15% coinsurance	35% coinsurance	None
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	Check with plan.
	Emergency medical transportation	15% coinsurance	15% coinsurance	Check with plan.
	Urgent care	15% coinsurance	35% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	35% coinsurance	Preauthorization required. $300 penalty and 50% coinsurance if not preauthorized out-of-network.
	Physician/surgeon fees	15% coinsurance	35% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	35% coinsurance	None
	Inpatient services	15% coinsurance	35% coinsurance	Preauthorization required. $300 penalty and 50% coinsurance if not preauthorized out-of-network.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	15% coinsurance	35% coinsurance	None
	Childbirth/delivery professional services	15% coinsurance	35% coinsurance	Hospital notification required; newborns must be enrolled in coverage within 30 days of their date of birth.
	Childbirth/delivery facility services	15% coinsurance	35% coinsurance	Hospital notification required; newborns must be enrolled in coverage within 30 days of their date of birth. $300 penalty and 50% coinsurance if not preauthorized out-of-network.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	35% coinsurance	Combined in-network and out-of-network limit of 90 visits per calendar year; no prior hospitalization is required.
	Rehabilitation services	15% coinsurance	35% coinsurance	Check with plan for physical, speech and occupational therapy in-network and out-of-network limits and requirements. Subject to medical necessity and ongoing improvement.
	Habilitation services	15% coinsurance	35% coinsurance	Check with plan for physical, speech and occupational therapy in-network and out-of-network limits and requirements. Subject to medical necessity and ongoing improvement.
	Skilled nursing care	15% coinsurance	35% coinsurance	Combined in-network and out-of-network limit of 60 days per calendar year.
	Durable medical equipment	15% coinsurance	35% coinsurance	Limitations apply. Preauthorization may be required.
	Hospice services	15% coinsurance	35% coinsurance	Preauthorization required.
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.)

- Cosmetic surgery
- Dental and eye care (Child)
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs (except nutritional counseling)

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

- Acupuncture (limitations apply)
- Bariatric surgery (if determined to be medically appropriate by claims administrator)
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (if determined to be medically appropriate by claims administrator; limitations apply)

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 866-444-3272 or dol.gov/ebsa or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or hhs.gov. 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 HealthCare.gov or call 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 at P.O. Box 740800, Atlanta, GA 30374 or the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

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 833-935-3328.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-935-3328.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 833-935-3328.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 833-935-3328.

*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	$900
Specialist cost sharing	15%
Hospital (facility) cost sharing	15%
Other cost sharing	15%

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	**$12,731**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$0
Coinsurance	$1,735
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,695**

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

The plan's overall deductible	$900
Specialist cost sharing	15%
Hospital (facility) cost sharing	15%
Other cost sharing	15%

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	**$7,389**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$0
Coinsurance	$1,705
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,660**

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

The plan's overall deductible	$900
Specialist cost sharing	15%
Hospital (facility) cost sharing	15%
Other cost sharing	15%

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	**$1,925**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$0
Coinsurance	$154
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,054**

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