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 **www.welcometouhc.com** or by calling **1-800-782-3740.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$1,250** Indiv **/ $3,750** Family Non-Network: **$2,500** Indiv **/ $7,500** Family Per calendar year. Does not apply to prescription drugs, services listed below as "No Charge" and copays except as noted below.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. 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 other deductibles for specific services?	No.	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.
Is there an out-of-pocket limit on my expenses?	Yes, Network: **$2,000** Indiv **/ $6,000** Family Non-Network: **$5,000** Indiv **/ $10,000** Family	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see **www.welcometouhc.com** or call **1-800-782-3740.**	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 I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	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**.

Questions: Call **1-800-782-3740** or visit us at **www.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 **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	20% co-ins, after ded	Virtual visits (Telehealth) - $25 copay per visit by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$50 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$25 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Preventive care/screening/immunizati-on	No Charge	Not Covered *	*Certain services are covered when using a non-network provider. Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	$200 copay per service	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
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	Retail: $20 copay Mail-Order: $60 copay Specialty Drugs: $20 copay	Retail: $20 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 Pre-Authorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable Copay and/or Co-ins may be applied. Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: $65 copay Mail-Order: $195 copay Specialty Drugs: $100 copay	Retail: $65 copay	
	Tier 3 - Your Highest-Cost Option	Retail: $100 copay Mail-Order: $300 copay Specialty Drugs: $300 copay	Retail: $100 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Retail: $200 copay Mail-Order: $600 copay Specialty Drugs: $500 copay	Retail: $200 copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	$200 copay per visit	$200 copay per visit	None
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	Network Deductible applies.
	Urgent care	$75 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Physician/surgeon fee	0% co-ins, after ded	20% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copay per visit	20% co-ins, after ded	Partial hospitalization/intensive outpatient therapy: No Charge Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Mental/Behavioral health inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	$50 copay per visit	20% co-ins, after ded	Partial hospitalization/intensive outpatient therapy: No Charge Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
If you are pregnant	Prenatal and postnatal care	No Charge	20% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	0% co-ins, after ded	20% co-ins, after ded	Inpatient Authorization may apply.
If you need help recovering or have other special health needs	Home health care	0% co-ins, after ded	20% co-ins, after ded	Limited to 40 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Rehabilitation services	$25 copay per outpatient visit	20% co-ins, after ded	Limits per policy period: Physical, Speech, Occupational, 30 visits. Pulmonary unlimited. Cardiac 36 visits. Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Habilitative services	$25 copay per outpatient visit	20% co-ins, after ded	Services provided under and limits are combined with Rehabilitation services above. Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Skilled nursing care	0% co-ins, after ded	20% co-ins, after ded	Nursing limited to 60 days per policy period. (Inpatient Rehabilitation limited to 30 days). Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Durable medical equipment	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Hospice service	0% co-ins, after ded	20% co-ins, after ded	Inpatient Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Eye exam	$10 copay per visit	20% co-ins, after ded	One exam every 12 months.
	Glasses	$25 copay per pair	20% co-ins, after ded	One pair every 12 months. Cost may increase depending on the frames selected.
	Dental check-up	0% co-ins, after ded	20% co-ins, after ded	Cleanings covered 2 times per 12 months. Additional limitations may apply.

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Chiropractic care
- Hearing aids

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 us at 1-800-782-3740; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Florida Department of Financial Services at 1-877-693-5236 or www.myfloridacfo.com.

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 1-800-782-3740

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-782-3740

Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-800-782-3740

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

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.

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.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,120
- **Patient pays** $1,420

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	$1,200
Copays	$20
Coinsurance	$0
Limits or exclusions	$200
Total	**$1,420**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,360
- **Patient pays** $2,040

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	$200
Copays	$1,800
Coinsurance	$0
Limits or exclusions	$40
Total	**$2,040**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by 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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