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, www.healthscopebenefits.com. 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.healthcare.gov/sbc-glossary or call 1-800-592-3943 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,000** Employee, **$2,000** Family Non-network: **$3,000** Employee, **$6,000** Family	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 is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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://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: **$2,500** Employee, **$7,500** Family Non-network: **$7,500** Employee, **$22,500** 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, penalties, amounts over Usual and Customary fees and excluded charges.	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. Call 1-800-592-3943 or visit www.healthscopebenefits.com 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 don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

Benefit	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
UHC Gold Plan	$100	$250	$155	$400

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	$20 copay	40% coinsurance	None
	Specialist visit	$30 copay	40% coinsurance	
	Preventive care/screening/ immunization	No Charge	40% coinsurance	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)	No Charge	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.southernscripts.net**	Generic drugs	1-30 day : $15 copay 31-60 day: $30 copay 61-90 day: $45 copay	Retail 50% coinsurance	None
	Preferred brand drugs	1-30 day : $30 copay 31-60 day: $45 copay 61-90 day: $60 copay	Retail 50% coinsurance	
	Non-preferred brand drugs	1-30 day : $50 copay 31-60 day: $75 copay 61-90 day: $100 copay	Retail 50% coinsurance Up to $1,000	
	Specialty drugs	30% coinsurance $500 Maximum	Retail 50% coinsurance Up to $1,000	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Precertification is required
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay 10% coinsurance	$150 copay 10% coinsurance	Copay waived if admitted to hospital.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$30 copay	40% coinsurance	None
If you have a hospital	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Precertification is required

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)	
stay	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay	40% coinsurance	None
	Inpatient services	10% coinsurance	40% coinsurance	Precertification is required
If you are pregnant	Office visits	$20 copay	40% coinsurance	There is no charge and the deductible does not apply to preventive prenatal care and certain breastfeeding support and supplies from a participating provider.
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	Precertification is required for inpatient Hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section).
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Limited to 100 visits per Calendar Year.
	Rehabilitation services	10% coinsurance	40% coinsurance	Occupational, Physical, and Speech therapy are each limited to 20 visits per year. Cardiac rehabilitation is limited to 36 visits.
	Habilitation services	10% coinsurance	40% coinsurance	
	Skilled nursing care	10% coinsurance	40% coinsurance	Limited to 100 inpatient days per Calendar Year.
	Durable medical equipment	10% coinsurance	40% coinsurance	Precertification is required.
	Hospice services	No Charge	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Under 6 No Charge Over 6 10% coinsurance	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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Foot Care
- 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)
- Chiropractic Care (20 visits)
- Hearing Aids
- Routine eye care (Adult)

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. 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 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: HealthSCOPE Benefits at 1-800-592-3943.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-592-3943.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-592-3943.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-592-3943.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-592-3943.

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.healthscopebenefits.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	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$80
Coinsurance	$1,240
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,380**

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

The plan's overall deductible	$1,000
Specialist copayment	$30
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,075
Coinsurance	$186
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,316**

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

The plan's overall deductible	$1,000
Specialist copayment	$30
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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$967
Copayments	$240
Coinsurance	$107
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,314**

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