## Important Questions | Answers | Why this Matters:
--- | --- | ---
What is the overall deductible? | Network: $500 Individual / $1,000 Family  
Non-Network: Not Covered  
Does not apply to copays, and services listed below as “No Charge”. | 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, there are no other **deductibles**. | You don’t have to meet **deductibles** for specific service, 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? | Medical-  
Network: $3,300 Individual / $6,600 Family  
Non-Network: Not Covered | The **out-of-pocket limit** is the most you could pay during a calendar 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**, balanced-billed charges, health care this plan doesn’t cover. | 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? | This policy has no overall annual limit on the amount it will pay each year. | The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits. |
Does this plan use a network of providers? | Yes, this plan uses **network providers**. If you use a **non-network provider** your cost may be more. For a list of **network providers**, see [www.welcometouhc.com/uhg](http://www.welcometouhc.com/uhg) or call 1-800-357-1371. | If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term 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**. This plan will pay some or all of the costs to see a **specialist** but only if you have the plan’s permission before you see the **specialist** for covered services. |
Do I need a referral to see a specialist? | Yes. Online referral is required to see a specialist. | |
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**. |
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

#### Coverage Period: 01/01/2017-12/31/2017

- **Kelsey-Seybold Primary Care Plan**

**Coverage for:** Employee/Family | **Plan Type:** GIL

- **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 only covers services if rendered by network **providers**. Exceptions include emergency services as described in your policy.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td><strong>Primary care visit to treat an injury or illness</strong></td>
<td>$10 Copay/visit</td>
<td>Not Covered</td>
<td>Virtual visit - Network $0 copay per visit by a Designated Virtual Network Provider. No Non-Network virtual visit coverage. If you receive services in addition to office visit, additional deductibles or co-ins may apply.</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist visit</strong></td>
<td>$30 Copay/visit</td>
<td>Not Covered</td>
<td>PCP online referral required for Specialist services otherwise no benefits due. Non-Network not covered.</td>
</tr>
<tr>
<td></td>
<td><strong>Other practitioner office visit</strong></td>
<td>$30 Copay/visit</td>
<td>Not Covered</td>
<td>Cost Share applies for only Manipulative (Chiropractic) Care. 20 visits per calendar year. Non-Network not covered.</td>
</tr>
<tr>
<td></td>
<td><strong>Preventive care/ screening/immunization</strong></td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Includes preventive health services specified in the health care reform law. Non-Network not covered.</td>
</tr>
<tr>
<td>If you have a test</td>
<td><strong>Diagnostic test (x-ray, blood work)</strong></td>
<td>20% Coinsurance After Deductible</td>
<td>Not Covered</td>
<td>Non-Network not covered.</td>
</tr>
<tr>
<td></td>
<td><strong>Imaging (CT/PET scans, MRIs)</strong></td>
<td>20% Coinsurance After Deductible</td>
<td>Not Covered</td>
<td>Non-Network not covered.</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2017-12/31/2017  
**Coverage for:** Employee/Family | **Plan Type:** GIL

### Common Medical Event

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
</table>
| **If you need drugs to treat your illness or condition** | Tier 1 - Your Lowest-Cost Option – Preventive  
Retail: $15 Copay  
Mail Order: $35 Copay  
Tier 2 - Your Midrange-Cost Option – Preventive  
Retail: $40 Copay  
Mail Order: $90 Copay  
Tier 3 - Your Highest-Cost Option – Preventive  
Retail: $85 Copay  
Mail Order: $190 Copay  
Tier 4 - Additional High-Cost Option – Non-Preventive; Specialty Pharmacy  
Retail: 20% Coinsurance After Deductible  
Mail Order: 20% Coinsurance After Deductible | | | Retail - Up to 31 day supply.  
Mail - Up to 90 day supply. Preventive copays apply to Network out-of-pocket. Non-Preventive coinsurance applies to Network out-of-pocket.  
Certain drugs may require prior authorization.  
You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.  
Specialty Rx - No grace fills at Retail. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center)  
20% Coinsurance After Deductible  
Physician/surgeon fees  
20% Coinsurance After Deductible | 20% Coinsurance After Deductible  
Not Covered | 20% Coinsurance After Deductible  
Not Covered | Non-Network not covered. |
| **If you need immediate medical attention** | Emergency room services  
Emergency medical transportation  
Urgent care | $300 Copay/visit  
20% Coinsurance After Deductible  
$50 Copay/visit | $300 Copay/visit  
20% Coinsurance After Deductible  
Not Covered | Non-Emergent Emergency Room Services not covered.  
Prior Authorization required for non-Emergency Ambulance or no coverage.  
Non-Network not covered. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room)  
Physician/surgeon fee | 20% Coinsurance After Deductible  
20% Coinsurance After Deductible | 20% Coinsurance After Deductible  
Not Covered | Non-Network not covered.  
Non-Network not covered.  
Non-Network not covered. |

# Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** Employee/Family  
**Plan Type:** GIL

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental/Behavioral health outpatient services</td>
<td>$10 Copay/visit</td>
<td>Not Covered</td>
<td>Partial hospitalization/intensive outpatient treatment – 20% coinsurance after deductible. EAP - 5 visits per member per problem per year.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% Coinsurance After Deductible</td>
<td>Not Covered</td>
<td>Non-Network not covered.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$10 Copay/visit</td>
<td>Not Covered</td>
<td>Partial hospitalization/intensive outpatient treatment – 20% coinsurance after deductible. EAP - 5 visits per member per problem per year.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>20% Coinsurance After Deductible</td>
<td>Not Covered</td>
<td>Non-Network not covered.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>20% Coinsurance After Deductible</td>
<td>Not Covered</td>
<td>Your cost in this category includes physician delivery charges. Routine pre-natal care is covered at No Charge.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% Coinsurance After Deductible</td>
<td>Not Covered</td>
<td>Your cost for inpatient services only. For physician delivery charges, see pre-postnatal care.</td>
</tr>
</tbody>
</table>
# Summary of Benefits and Coverage: What this Plan Covers & What it Costs

## Coverage Period: 01/01/2017-12/31/2017

### Coverage for: Employee/Family | Plan Type: GIL

#### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>20% Coinsurance After Deductible</td>
<td>Not Covered</td>
<td>60 visits per calendar year. Non-Network not covered.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$30 Copay/visit</td>
<td>Not Covered</td>
<td>Phys &amp; Occ Therapy=60 visits comb; Speh Therapy=90 visits; Cardiac Rehab=36 visits; Pulm Rehab=20 visits. All limits per cal year. Non-Network not covered.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% Coinsurance After Deductible</td>
<td>Not Covered</td>
<td>60 days per calendar year. Non-Network not covered.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% Coinsurance After Deductible</td>
<td>Not Covered</td>
<td>Non-Network not covered.</td>
</tr>
<tr>
<td>Hospice service</td>
<td>20% Coinsurance After Deductible</td>
<td>Not Covered</td>
<td>180 days maximum per lifetime. Non-Network not covered.</td>
</tr>
</tbody>
</table>

If your child needs dental or eye care

| Eye exam                                   | Not Covered                            | Not Covered                              | Not Covered               |
| Glasses                                    | Not Covered                            | Not Covered                              | Not Covered               |
| Dental check-up                            | Not Covered                            | Not Covered                              | Not Covered               |

### 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.)

- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing

**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.)

- Acupuncture limitations may apply
- Chiropractic care limitations may apply
- Applied Behavioral Analysis (ABA)
- Non-emergency care when traveling outside the U.S.
- Routine foot care limitations may apply
- Weight loss programs limitations may apply
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 1-866-747-0048. 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 1-800-357-1371 or visit www.myuhc.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 1-800-357-1371.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-357-1371.
- Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-357-1371.
- Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-357-1371.

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 also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,520
- **Patient pays:** $2,020

**Sample care costs:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$7,540</td>
</tr>
</tbody>
</table>

**Patient pays:**

- **Deductibles** $500
- **Copays** $20
- **Coinsurance** $1,350
- **Limits or exclusions** $150
- **Total** $2,020

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,840
- **Patient pays:** $1,560

**Sample care costs:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$5,400</td>
</tr>
</tbody>
</table>

**Patient pays:**

- **Deductibles** $500
- **Copays** $950
- **Coinsurance** $30
- **Limits or exclusions** $80
- **Total** $1,560
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.

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.