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, call 1-800-833-2980 or 713-869-2592. 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 1-800-833-2980 or 713-869-2592 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$750**/individual; **$1,500**/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. Most preventive care and hearing aids are 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.
Are there other deductibles for specific services?	Yes. **$100**/individual for dental. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network providers: **$9,000**/ individual; Out-of-network providers: **$30,000**/individual	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization, health care this plan doesn't cover and deductibles.	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.uhc.com/find-a-doctor or call the phone number on your member ID card for a list of medical network providers. See www.VSP.com or call 1-800-877-7195 for a list of vision 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	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge for sigmoidoscopies, mammograms, pap smears, prostate exams and the following vaccines: tetanus, pneumonia, flu, hepatitis A&B and meningitis. No charge up to $400 for routine physicals then 20% coinsurance. No charge up to $400/lifetime then 20% coinsurance for HPV vaccines. No charge up to $400/lifetime then 20% coinsurance for shingles vaccines. Immunizations not listed above: 20% coinsurance not subject to the deductible (individuals under age 19); No charge (individuals age 19 and over).	No charge for sigmoidoscopies and the following vaccines: tetanus, pneumonia and flu. No charge up to $400 for routine physicals then 40% coinsurance. No charge up to $400/lifetime then 40% coinsurance for HPV vaccines. No charge up to $400/lifetime then 40% coinsurance for shingles vaccines. 40% coinsurance for hepatitis A&B and meningitis vaccines. 40% coinsurance for mammograms, pap smears, prostate exams and child immunizations.	Tetanus vaccine limited to one every 10 years. Pneumonia vaccine limited to one every 6 years. Hepatitis A vaccine limited to individuals under age 19. Shingles vaccine limited to individuals age 50 and older. Routine physicals limited to one per year for individuals over 40 and one per every 5 years for individuals under 40. Sigmoidoscopies limited to $250 per exam. In addition, age and frequency limitations apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check the services for which your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Retail: 15% coinsurance for up to a 90-day supply; mail order: 10% coinsurance for a 90-day supply	Retail: 15% coinsurance for up to a 90-day supply; mail order: 10% coinsurance for a 90-day supply	For all types of drugs, you will be responsible for 100% of the medication up to the first $5.00. For amounts in excess of $5.00, you pay the applicable coinsurance. If you choose a preferred brand or non-preferred brand drug instead of its generic equivalent, you will pay the applicable brand coinsurance plus a penalty. The penalty is the difference in cost between the brand and generic medications. If your physician prescribes as brand only, you will pay the applicable coinsurance and a penalty does not apply. If you choose a preferred brand or non-preferred brand drug instead of its generic equivalent, you will pay the applicable brand coinsurance plus a penalty. The penalty is the difference in cost between the brand and generic medications. This penalty applies even if your doctor writes "dispense as written" (DAW) on the prescription.
	Preferred brand drugs	Retail: 20% coinsurance for up to a 30-day supply, 15% coinsurance for a 90-day supply; mail order: 10% coinsurance for a 90-day supply	Retail: 20% coinsurance for up to a 30-day supply, 15% coinsurance for a 90-day supply; mail order: 10% coinsurance for a 90-day supply	
	Non-preferred brand drugs	Retail: 20% coinsurance for up to a 90-day supply; mail order: 20% coinsurance for a 90-day supply	Retail: 20% coinsurance for up to a 90-day supply; mail order: 20% coinsurance for a 90-day supply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

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 need immediate medical attention	Emergency room care	$100 emergency room copay, then 20% coinsurance	$100 emergency room copay, then 20% coinsurance	Emergency room copay waived if admitted to the hospital directly from emergency room. Deductible applies if admitted. Professional/ physician charges may be billed separately.
	Emergency medical transportation	20% coinsurance	20% coinsurance for air ambulance; 40% coinsurance for other ambulance services	None
	Urgent care	20% coinsurance. No charge for urgent care services at Next Level Urgent Care facilities. See www.nextlevelurgentcare.com for more information.	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance if admitted directly through hospital's emergency room; otherwise not covered	Must pre-certify out-of-network non-emergency hospital confinements and certify out-of-network emergency hospital confinements, otherwise, benefits reduced to 50% co-insurance and limited to maximum of $1,000 for entire confinement. Room and board limited to the average semi-private room rate; no additional benefits for private room.
	Physician/surgeon fees	20% coinsurance	40% coinsurance if admitted directly through hospital's emergency room; otherwise 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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance for mental/behavioral health; substance abuse services not covered	40% coinsurance for mental/behavioral health; substance abuse services not covered	None
	Inpatient services	20% coinsurance for mental/behavioral health; substance abuse services not covered	40% coinsurance for mental/behavioral health; substance abuse services not covered	Must pre-certify out-of-network non-emergency mental/behavioral health hospital confinements and certify out-of-network emergency mental/behavioral health hospital confinements, otherwise, benefits reduced to 50% coinsurance and limited to maximum of $1,000 for entire confinement.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Not covered for dependent children. Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Must be home bound.
	Rehabilitation services	20% coinsurance	40% coinsurance	Outpatient physical therapy not following surgery limited to combined in- and out-of-network maximum of 24 visits.
	Habilitation services	Not covered	Not covered	You must pay 100% of these services.
	Skilled nursing care	20% coinsurance	40% coinsurance	None
	Durable medical equipment	20% coinsurance	40% coinsurance	Durable medical equipment in excess of $200 not covered without pre-determination of benefits through Fund Office.
	Hospice services	20% coinsurance	40% coinsurance	None

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 your child needs dental or eye care	Children's eye exam	$25 copay for exam and glasses combined.	No charge up to $45, then 100%.	Limited to one exam every 12 months for children. Vision coverage is subject to a separate election.
	Children's glasses	$25 copay for exam and glasses combined, plus 100% of frame costs in excess of $230.	Single vision lenses: No charge up to $30, then 100%; Frames: No charge up to $70, then 100%.	Limited to one pair of lenses and frames every 12 months for children. Vision coverage is subject to a separate election.
	Children's dental check-up	No charge	No charge	Limited to one check-up per calendar year for individuals age 18 and older, subject to the $2,000 calendar year maximum. For individuals under age 18, limited to two check-ups per calendar year, not subject to the $2,000 calendar year maximum: first checkup – exam, prophylaxis, x-rays and fluoride covered at no charge; second checkup – only exam and prophylaxis coverage at no charge. Dental coverage is subject to a separate election.

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 (except for treatment within 6 consecutive months following an injury to correct a condition that resulted from an accident or as required by law)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Chiropractic care
- Dental care (Adult) (limited to $2,000 per calendar year)
- Hearing aids (limited to maximum payable of $1,500 per 3-calendar year benefit period)
- Private-duty nursing (limited to maximum payable of $15,000 per calendar year)

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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: 1-800-833-2980 or 713-869-2592. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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? **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 1-800-833-2980 or 713-869-2592

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** **$680**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$750
Copayments	$0
Coinsurance	$2,370
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,180**

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

- **The plan's overall deductible** **$680**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$750
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$250
The total Joe would pay is	**$1,900**

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

- **The plan's overall deductible** **$680**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$850
Copayments	$0
Coinsurance	$370
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,220**

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