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 1-800-528-1530. 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.mybenemax.com keyword: **WMD** or call 1-800-528-1530 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500** Individual contract, **$3,000** Family contract per policy year	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 policy, the overall family deductible must be met before the plan begins to pay.
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?	**$6,350** Individual, **$12,700** 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 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 and health care this plan 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. See www.welcometouhc.com or call 1-800-444-6222 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 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	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important

Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not covered	Deductible applies first; Virtual visits (Telehealth) 0% coinsurance by a Designated Virtual Network Provider
	Specialist visit	20% coinsurance	Not covered	Deductible applies first
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not covered	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)	20% coinsurance	Not covered	Deductible applies first
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Deductible applies first
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.myuhc.com	Tier 1	No charge	Not covered	Deductible applies first; Provider means pharmacy for purposes of this section. Retail: Up to a 90 day supply. Copays shown are for a 30 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 2	No charge	Not covered	
	Tier 3	No charge	Not covered	
	Tier 4	Not applicable	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Deductible applies first
	Physician/surgeon fees	20% coinsurance	Not covered	Deductible applies first
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Deductible applies first
	Emergency medical transportation	20% coinsurance	20% coinsurance	Deductible applies first
	Urgent care	20% coinsurance	Not covered	Deductible applies first
If you have a hospital	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Deductible applies first

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
stay	Physician/surgeon fees	20% coinsurance	Not covered	Deductible applies first
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not covered	Deductible applies first; network partial hospitalization/intensive outpatient treatment: 20% coinsurance.
	Inpatient services	20% coinsurance	Not covered	Deductible applies first
If you are pregnant	Office visits	No charge; deductible does not apply	Not covered	Deductible applies first; cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); inpatient preauthorization may apply.
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Deductible applies first; limited to 60 visits per policy year
	Rehabilitation services	20% coinsurance	Not covered	Deductible applies first; limits per policy year; physical, speech, and occupational therapy combined limit 60 visits
	Habilitation services	20% coinsurance	Not covered	Deductible applies first; limits per policy year; physical, speech, and occupational therapy combined limit 60 visits
	Skilled nursing care	20% coinsurance	Not covered	Deductible applies first; limited to 30 visits per policy year
	Durable medical equipment	No charge	Not covered	Deductible applies first; Preauthorization required for DME over $500 or there is no coverage
	Hospice services	20% coinsurance	Not covered	Deductible applies first; Limited to 180 days per lifetime (combined inpatient and home hospice).
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for Children's eye exam
	Children's glasses	Not covered	Not covered	No coverage for Children's glasses
	Children's dental check-up	Not covered	Not covered	No coverage for Children's dental check-up

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.)		
• Acupuncture • Children's glasses • Cosmetic Surgery • Dental care (Adult/Child)	• Long-term care • Non-emergency care when traveling outside the US. • Private-duty nursing	• Routine Eye Care (adult/child) • Routine Foot Care- except as covered for diabetes • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic (manipulative) care- 30 visits per policy year	• Hearing aids	• Infertility Treatment

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Department of Health and Human Services, Center of Consumer Information, and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.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 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: your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the New York Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov/index.htm.

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 1-866-633-2446]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-633-2446.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.]

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	$1,500
■ Delivery fee coinsurance	20%
■ Facility fee coinsurance	20%
■ Diagnostic tests 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	$1,500
Copayments	$0
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,360**

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

■ The plan's overall deductible	$1,500
■ Specialist visit coinsurance	20%
■ Primary care visit coinsurance	20%
■ Diagnostic tests 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	$900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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

■ The plan's overall deductible	$1,500
■ Specialist visit coinsurance	20%
■ Emergency room coinsurance	20%
■ Ambulance services 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	$1,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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