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, contact Health Design Plus at 1-877-230-0992 or www.hdplus.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.cciio.cms.gov or call 1-877-230-0992 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**No**	You will have to meet the deductible before the plan pays for any services.
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?	**Medical Network & Out-of-Network:** $3,175 individual / $6,350 family **Separate out-of-pocket limit for RX:** $3,175 individual / $6,350 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 limit until the overall family out-of-pocket limit had been met.
What is not included in the out-of-pocket limit?	**Yes**. Premiums, balance-billing charges, cost containment penalties, and health care this plan does not 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.myuhchoice.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 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	$10 copayment/visit	Not Covered	None
	Specialist visit	$25 copayment/visit	Not Covered	None
	Preventive care/screening/ immunization	No Charge	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)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 1-800-228-6472 or at https://member.medmutual.com	Generic drugs	Retail: $5 copayment/ Prescription Mail Order: $5 copayment/ prescription	Not Covered	Covers up to a 31-day supply at a retail pharmacy and up to a 90-day supply through mail order.
	Preferred brand drugs	Retail: $10 copayment/ Prescription Mail Order: $10 copayment/ prescription	Not Covered	Covers up to a 31-day supply at a retail pharmacy and up to a 90-day supply through mail order.
	Non-preferred brand drugs	Retail: $10 copayment/ Prescription Mail Order: $10 copayment/ prescription	Not Covered	Covers up to a 31-day supply at a retail pharmacy and up to a 90-day supply through mail order.
	Specialty drugs	Retail: $10 copayment/ Prescription Mail Order: $10 copayment/ prescription	Not Covered	Covers up to a 31-day supply at a retail pharmacy and up to a 90-day supply through mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 copayment/visit	Not Covered	Preauthorization may be required for certain services. Failure to receive preauthorization could result in no coverage.
	Physician/surgeon fees	No Charge	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 immediate medical attention	Emergency room care	$50 copayment/visit		None
	Emergency medical transportation	No Charge		None
	Urgent care	$25 copayment/visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Preauthorization may be required for certain services. Failure to receive preauthorization could result in no coverage.
	Physician/surgeon fees	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copayment/visit	Not Covered	None
	Inpatient services	No Charge	Not Covered	Preauthorization may be required for certain services. Failure to receive preauthorization could result in no coverage.
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge	Not Covered	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Preauthorization may be required for certain services. Failure to receive preauthorization could result in no coverage.
	Rehabilitation services	$10 copayment/visit	Not Covered	Limited to 30 visits per year. Preauthorization may be required for certain services. Failure to receive preauthorization could result in no coverage.
	Habilitation services	$10 copayment/visit	Not Covered	Limited to 8 visits per lifetime.

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)	
	Skilled nursing care	No Charge	Not Covered	Limited to a 100 days per year. Preauthorization may be required for certain services. Failure to receive preauthorization could result in no coverage.
	Durable medical equipment	No Charge	Not Covered	Preauthorization may be required for certain services. Failure to receive preauthorization could result in no coverage.
	Hospice services	No Charge	Not Covered	Preauthorization may be required for certain services. Failure to receive preauthorization could result in no coverage.
If your child needs dental or eye care	Children's eye exam	$25 copayment/visit	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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- 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.)

- Infertility treatment, with limitations
- 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 ext. 61565 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: 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
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 1-877-230-0992.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-230-0992.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-230-0992.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-230-0992.

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	$0
Primary care copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$70**

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

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$460**

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

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$180**

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