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November 1, 2023

TO: All Employees

FROM: Tracy Henderlight

RE: Employee Health Coverage Options and Other Insurance Information

This document and all attachments are being provided to inform employees of your health insurance options. For the plan year 12/1/2023 through 11/30/2024 the employer-sponsored health coverage is with United Healthcare.

Employee-sponsored coverage is available to all FULL-TIME employees who work a minimum of 30 hours per week for 121 days or more per year. Employees who meet these criteria are eligible to enroll in the medical plan after 30 days of employment. Once enrolled, coverage begins on the 1st day of the month following the 30th day of employment. If enrollment is waived at initial eligibility, employees and dependents can enroll during the open enrollment period which is Nov 1 to Dec 15 each year.

For the 2023-24 plan year participating employees are responsible to pay 8.39% of their gross income for HEALTH insurance premiums up to a maximum of ½ the monthly premium which is \$387.51/month (payroll deduction of \$89.43 per week). Deductions will be recalculated quarterly based on average gross income for the previous calendar quarter.

Examples:

- 1) Employee salary \$600 / week for the previous quarter:
 $\$600 \times 8.39\% = \50.34 weekly payroll deduction for health insurance
- 2) Employee averaged \$1075 / week in commission for the previous quarter:
 $\$1075 \times 8.39\% = \90.19
Max is \$89.43 which would be the weekly payroll deduction for health insurance
- 3) Employee pay \$14.00/hour for 40 hours = average \$560/week for the previous quarter:
 $\$560 \times 8.39\% = \46.98 weekly payroll deduction for health insurance

This does NOT apply to dental, vision or any supplemental plans and does NOT reflect premiums for dependent coverage. If you choose to enroll in additional plans or wish to cover dependents, the premiums for the additional coverage will be paid by the employee in full via additional payroll deduction. Etsell, Inc. will provide life insurance coverage at no cost for all participants on the health plan.

Etsell, Inc. reserves the right to pay an additional portion of any premiums up to 100% depending on length of employment, management positions or other factors.

Etsell, Inc. also offers a Health Savings Account (HSA) option which allows employees who subscribe to the UHC medical plan to make pretax contributions to a Health Savings Account. The employee can then use the HSA to pay deductibles, copays and for certain medical supplies. For the calendar year 2024 employees can contribute to the HSA through pretax payroll deductions in any amount up to an annual maximum of \$4150 for individuals under the age of 55, \$5150 for individuals over 55, \$8300 for families if covered employee is under the age of 55 or \$9300 for families if covered employee is 55 or older. If an employee chooses to contribute to an HSA, please notify OpCenter for sign-up instructions.

For Medicare-eligible subscribers, the prescription drug coverage available under the company's group medical plan has been reviewed and found to be a non-creditable plan. Prescription coverage is non-creditable if the total expected paid claims for Medicare-eligible subscribers will be less under the group plan than total expected paid claims for the same subscriber under the defined standard prescription drug coverage under Medicare Part D. Each Medicare-eligible subscriber should review their own individual circumstances to determine their need to enroll in Medicare Part D. Additional information regarding Medicare can be found at www.medicare.gov.

Depending on the percentage of income it costs an employee to pay their portion of the company group health plan premium, employees also have the option to seek insurance coverage through the Marketplace. The Marketplace will be managed by each state or by the federal government depending on the state the employee resides in. Visit www.Healthcare.gov for more information on eligibility, enrollment, available coverage and premiums through the Marketplace. If an employee purchases a qualified health plan through the Marketplace, the employee loses the employer contribution to any employer-sponsored health plans.

All individuals are required to have minimum essential coverage, and individuals without the required coverage may pay a penalty assessed via tax return.

Please call Operations Center with any questions.

Thank you,
Tracy Henderlight
Etsell, Inc.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Tracy Henderlight at the Knoxville OpCenter at (865) 588-9698.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name ETSELL INC		4. Employer Identification Number (EIN) 59-1672120	
5. Employer address 139 FOX RD STE 105		6. Employer phone number 865-588-9698	
7. City KNOXVILLE	8. State TN	9. ZIP code 37922	
10. Who can we contact about employee health coverage at this job? TRACY HENDERLIGHT			
11. Phone number (if different from above)		12. Email address INFO@SHRINESERVICES.COM	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

All employees. Eligible employees are:

- Some employees. Eligible employees are:

Full-time employees who have worked at least 30 days.

Employees are considered full-time if they work a minimum of 30 hours per week for at least 121 days per year.

- With respect to dependents:

- We do offer coverage. Eligible dependents are:

- Spouse of covered employee
- [Tennessee Code Ann. § 56-7-2302](#) dependent child up to age 24 provided the child is unmarried and financially dependent on the parents.
- [S.C. Code Ann. § 38-71-1330](#) unmarried, dependent child who is a full-time student up to age 22 if parent is covered by small group policy.
- [S.C. Code Ann. § 38-71-350](#) a dependent child incapable of self-sustaining employment without regard to age.
- [Florida 627.6562](#) dependent child up to age 25 who lives with parent or are a student, and up to age 30 if unmarried and have no dependent child of their own.

NOTE: An employee must have coverage on themselves to get coverage on dependents.

- We do not offer coverage.

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](#) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](#) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

Yes (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
 Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ 8.39% of gross income up to a maximum of \$387.51 per month which is 1/2 the monthly premium. Recalculated each calendar quarter.

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? N/A

Employer won't offer health coverage
 Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____
b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Choice Plus plan details, all in one place.

Use this benefit summary to learn more about this plan’s benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what’s included in the plan	Choice Plus
 <p>Network coverage only You can usually save money when you receive care for covered health care services from network providers.</p>	<input type="checkbox"/>
 <p>Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.</p>	<input checked="" type="checkbox"/>
 <p>Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.</p>	<input type="checkbox"/>
 <p>Referrals required You’ll need referrals from your PCP before seeing a specialist or getting certain health care services.</p>	<input type="checkbox"/>
 <p>Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.</p>	<input checked="" type="checkbox"/>
 <p>Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.</p>	<input type="checkbox"/>
 <p>Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.</p>	<input type="checkbox"/>
 <p>Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.</p>	<input type="checkbox"/>
 <p>Health savings account (HSA) With an HSA, you’ve got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.</p>	<input checked="" type="checkbox"/>

This Benefit Summary is to highlight your Benefits. Don’t use this document to understand your exact coverage. If this Benefit Summary conflicts with the Summary Plan Description (SPD), that document governs. Review your SPD for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Choice Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

*After the Annual Medical Deductible has been met.

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

	In Network	Out-of-Network
Annual Out-of-Pocket Limit		
Individual	\$6,900	\$20,000
Family	\$13,800	\$40,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

For the 2000X family plans, the out-of-pocket limit is capped at \$6,550 for an individual and \$8,000 for family.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Preventive Care Services		
Preventive Care Services	No copay	50%*
<p>Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.</p> <p>Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.</p>		
Office Services - Sickness & Injury		
Primary Care Physician	\$25 copay*	50%*
<p>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.</p> <p>Telehealth is covered at the same cost share as in the office.</p>		
Specialist	\$75 copay*	50%*
<p>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.</p> <p>Telehealth is covered at the same cost share as in the office.</p>		

*After the Annual Medical Deductible has been met.

*Prior Authorization Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network	Out-of-Network
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Urgent Care Center Services

\$50 copay*

50%*

Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.

Virtual Care Services

No copay*

50%*

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.

Emergency Care

Ambulance Services - Emergency Ambulance

Air Ambulance

50%*

50%*

Ground Ambulance

50%*

50%*

Ambulance Services - Non-Emergency Ambulance¹

Air Ambulance

50%*

50%*

Ground Ambulance

50%*

50%*

Dental Services - Accident Only

50%*

50%*

Emergency Health Care Services - Outpatient¹

\$300 copay then 50%*

\$300 copay then 50%*

Inpatient Care

Habilitative Services - Inpatient

The amount you pay is based on where the covered health care service is provided.

Hospital - Inpatient Stay¹

50%*

50%*

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services¹

50%*

50%*

Limited to 60 days per year.

Outpatient Care

Acupuncture Services

\$25 copay*

50%*

Limited to 10 treatments per year.

Habilitative Services - Outpatient

Manipulative treatment services

\$25 copay*

50%*

Other habilitative services

50%*

50%*

Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network	Out-of-Network
Home Health Care ¹	50%*	50%*
<i>Limited to 30 visits per year.</i>		
<i>One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.</i>		
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing ¹	50%*	50%*
<i>Limited to 18 Definitive Drug Tests per year.</i>		
<i>Limited to 18 Presumptive Drug Tests per year.</i>		
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing ¹	50%*	50%*
Major Diagnostic and Imaging - Outpatient ¹	50%*	50%*
Physician Fees for Surgical and Medical Services	50%*	50%*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Manipulative treatment services	\$25 copay*	50%*
Other rehabilitation services	50%*	50%*
<i>Limited to 20 visits of Manipulative Treatments per year.</i>		
<i>Limited to 30 combined visits of physical therapy, occupational therapy, speech therapy, cardiac therapy, post cochlear therapy, cognitive therapy and pulmonary therapy per year.</i>		
<i>Limits are combined with Habilitative Services - Outpatient.</i>		
Surgery - Outpatient ¹	50%*	50%*
Therapeutic Treatments - Outpatient ¹	50%*	50%*
<i>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.</i>		
Supplies and Services		
Diabetes Self-Management Items ¹	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.	
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care ¹	The amount you pay is based on where the covered health care service is provided.	
Durable Medical Equipment (DME), Orthotics and Supplies ¹	50%*	50%*
Enteral Nutrition	50%*	50%*

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network	Out-of-Network
Hearing Aids	50%*	50%*
<i>Limited to \$5,000 every 36 months ages 18 and over.</i>		
<i>Limited to 1 Bone Anchored Hearing Aid per lifetime.</i>		
<i>Limited to 1 hearing aid per ear every 36 months under the age of 18.</i>		
<i>Limited to a single purchase per hearing impaired ear every 36 months.</i>		
Ostomy Supplies	50%*	50%*
Pharmaceutical Products - Outpatient	50%*	50%*
<i>Depending on the pharmaceutical product prior authorization may be required.</i>		
<i>This includes medications given at a doctor's office, or in a covered person's home.</i>		
Prosthetic Devices ¹	50%*	50%*
Pregnancy		
Pregnancy - Maternity Services ¹	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Mental Health Care & Substance Related and Addictive Disorder Services		
Inpatient	50%*	50%*
Outpatient	\$75 copay*	50%*
Partial Hospitalization	50%*	50%*
<i>Limited to 60 days combined for residential treatment facility and skilled nursing facility per year.</i>		
Other Services		
Cellular and Gene Therapy	The amount you pay is based on where the covered health care service is provided.	
<i>For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.</i>		
Clinical Trials ¹	The amount you pay is based on where the covered health care service is provided.	
Gender Dysphoria ¹	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
Hospice Care ¹	50%*	50%*
Reconstructive Procedures ¹	The amount you pay is based on where the covered health care service is provided.	
Transplantation Services	50%*	Not covered
<i>Coverage is only available when services are performed at a Centers of Excellence facility, except for cornea transplants.</i>		

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to SPD.

Here's an example of how the plan's costs come into play.

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, \$15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.



Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to [welcometouhc.com](https://www.welcometouhc.com) > **Benefits** > **Find a Doctor or Facility**.
- Choose **Search for a health plan**.
- Choose **Choice Plus** to view providers in the health plan's network.



Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to [welcometouhc.com](https://www.welcometouhc.com) > **Benefits** > **Pharmacy Benefits**.
- Select **Advantage** to view the medications that are covered under your plan.



Access your plan online.

With [myuhc.com](https://www.myuhc.com)®, you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.



Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.

Good stuff that's good to know.

I dig it!

Other important information about your benefits.

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, the Prescription Drug Product is not eligible for benefits.

Certain Preventative Care Medications may be covered at zero costshare. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your SPD for additional exclusions and limitations that may apply.

- A Pharmaceutical Product for which Benefits are provided in your Summary Plan Description.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as required by state mandate.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Certain Prescription Drug Products for tobacco cessation.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
- Certain compounded drugs.
- Diagnostic kits and products.
- Drugs available over-the-counter.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Summary Plan Description. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- Experimental or Investigational or Unproven Services and medications.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Medications used for cosmetic purposes.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Prescription Drug Products when prescribed to treat infertility.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

UnitedHealthcare does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at:
<http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building Washington,
D.C. 20201

We provide free services to help you communicate with us such as letters in others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意: 如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (**Vietnamese**), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어 (**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (**Tagalog**), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русский (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تويغزللا تدعاسملا تامدخ ناف، (Arabic) ةيبرعلا تدحتت تنك اذا: ةيبنت
فقاظب لىع جردملا يناعملا فتاهل مقرب لاصتالا جري. لكل ةحاتم ةيناعملا
كعب فصاخلا فيرعتللا

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION: Si vous parlez français (**French**), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (**Polish**), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (**Portuguese**), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (**Italian**), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (**German**) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項: 日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (**Hmong**), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ΠΡΟΣΟΧΗ: Αν μιλάτε Ελληνικά (**Greek**), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.


PAKDAAR: Nu saritaem ti Ilocano (**Ilocano**), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yáníłt'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shóodí ninaaltsoos nít'ízi bee nééhozinígíí bine'déé' t'áá jíík'ehgo béesh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (**Somali**), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

ગુજરાતી (Gujarati): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વલના મૂલ્યે પ્રાપ્ય છે. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિ પર આપેલા સભ્ય માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.



 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 1-877-797-8812 or visit myuhc.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 1-877-797-8812 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$5,000 Individual / \$10,000 Family Out-of-Network: \$10,000 Individual / \$20,000 Family per year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive Care Services</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Network: \$6,900 Individual / \$13,800 Family Out-of-Network: \$20,000 Individual / \$40,000 Family per year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See myuhc.com or call 1-877-797-8812 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as <u>lab work</u>). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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	\$25 <u>copay</u> per visit	50% <u>coinsurance</u>	Virtual Visits - 0% <u>coinsurance</u> by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional <u>copays</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Specialist visit</u>	\$75 <u>copay</u> per visit	50% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>copays</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Preventive care/ screening/ immunization</u>	No Charge	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Imaging (CT/PET scans, MRIs)	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .

* For more information about limitations and exceptions, see the plan or policy document at myuhc.com.

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 myuhc.com	Tier 1 - Your Lowest Cost Option	Retail: \$10 <u>copay</u> Mail-Order: \$25 <u>copay</u> Specialty Retail: \$10 <u>copay</u>	Retail: \$10 <u>copay</u> Specialty Retail: \$10 <u>copay</u>	Provider means pharmacy for purposes of this section. Retail: Up to a 90 day supply. Mail-Order: Up to a 90 day supply. Specialty: Up to a 31 day supply. Specialty drugs are not covered through mail order. One retail <u>copay</u> applies per 31-day retail prescription. You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. If you use an <u>out of network</u> pharmacy, you may need to pay the cost up front, submit for reimbursement, and may be responsible for any amount over the <u>allowed amount</u> . Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable <u>copay</u> and/or <u>coinsurance</u> may be applied. Prescription drug costs are subject to the annual <u>deductible</u> . <u>Network deductible</u> will be applied to the <u>out-of-network provider</u> and applies to the <u>Network out-of-pocket limit</u> .
	Tier 2 - Your Mid-Range Cost Option	Retail: \$35 <u>copay</u> Mail-Order: \$87.50 <u>copay</u> Specialty Retail: \$150 <u>copay</u>	Retail: \$35 <u>copay</u> Specialty Retail: \$150 <u>copay</u>	
	Tier 3 - Your Mid-Range Cost Option	Retail: \$70 <u>copay</u> Mail-Order: \$175 <u>copay</u> Specialty Retail: \$350 <u>copay</u>	Retail: \$70 <u>copay</u> Specialty Retail: \$350 <u>copay</u>	
	Tier 4 - Your Highest Cost Option	Retail: \$150 <u>copay</u> Mail-Order: \$375 <u>copay</u> Specialty Retail: \$500 <u>copay</u>	Retail: \$150 <u>copay</u> Specialty Retail: \$500 <u>copay</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .

* For more information about limitations and exceptions, see the plan or policy document at myuhc.com.

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)	
	Physician/surgeon fees	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$300 <u>copay</u> per visit then 50% <u>coinsurance</u>	*\$300 <u>copay</u> per visit then 50% <u>coinsurance</u>	* <u>Network deductible</u> applies.
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	*50% <u>coinsurance</u>	* <u>Network deductible</u> applies.
	<u>Urgent Care</u>	\$50 <u>copay</u> per visit	50% <u>coinsurance</u>	Virtual Visits - 0% <u>coinsurance</u> by a Designated Virtual <u>Network Provider</u> . If you receive services in addition to <u>Urgent care</u> visit, additional <u>copays</u> or <u>coinsurance</u> may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$75 <u>copay</u> per visit	50% <u>coinsurance</u>	<u>Network Partial hospitalization/intensive outpatient treatment</u> : 50% <u>coinsurance</u>
	Inpatient services	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you are pregnant	Office Visits	Primary Care Visit: \$25 <u>copay</u> per visit Specialist Visit: \$75 <u>copay</u> per visit	50% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	50% <u>coinsurance</u>	50% <u>coinsurance</u>	

* For more information about limitations and exceptions, see the plan or policy document at myuhc.com.

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)	
	Childbirth/delivery facility services	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 30 visits per year. <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<u>Rehabilitation services</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	30 combined visits per year for <u>rehabilitation</u> and <u>habilitative services</u> . Includes physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy.
	<u>Habilitative services</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 days per year, combined with inpatient rehabilitation and residential treatment. <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for DME over \$1,000 or benefit reduces to 50% of <u>allowed amount</u> .
	<u>Hospice services</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of <u>allowed amount</u> .
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Bariatric surgery• Cosmetic Surgery• Dental Care• Glasses	<ul style="list-style-type: none">• Infertility Treatment• Long Term Care• Non-emergency care when traveling outside - the US	<ul style="list-style-type: none">• Private duty nursing• Routine Eye Care• Routine foot care - Except as covered for Diabetes
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none">• Acupuncture Services - 10 visits per year	<ul style="list-style-type: none">• Chiropractic (manipulative care) - 20 visits per year	<ul style="list-style-type: none">• Hearing aids - Limited to \$5,000 every 36 Months

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: 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. 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: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce & Insurance at 800-342-4029 or visit www.tn.gov/commerce/consumer-services.html.

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 1-877-797-8812.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-797-8812.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-797-8812.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-797-8812.

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$5,000	■ The plan's overall deductible	\$5,000	■ The plan's overall deductible	\$5,000
■ Specialist copay	\$75	■ Specialist copay	\$75	■ Specialist copay	\$75
■ Hospital (facility) coinsurance	50%	■ Hospital (facility) coinsurance	50%	■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%	■ Other coinsurance	50%	■ Other coinsurance	50%
This EXAMPLE event includes services like: <u>Specialist office visits</u> (pre-natal care) <u>Childbirth/Delivery Professional Services</u> <u>Childbirth/Delivery Facility Services</u> <u>Diagnostic tests</u> (ultrasounds and blood work) <u>Specialist visit</u> (anesthesia)		This EXAMPLE event includes services like: <u>Primary care physician office visits</u> (including disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose meter)		This EXAMPLE event includes services like: <u>Emergency room care</u> (including medical supplies) <u>Diagnostic test</u> (x-ray) <u>Durable medical equipment</u> (crutches) <u>Rehabilitation services</u> (physical therapy)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<u>Cost Sharing</u>		<u>Cost Sharing</u>		<u>Cost Sharing</u>	
<u>Deductibles</u>	\$5,000	<u>Deductibles</u>	\$1,700	<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0	<u>Copayments</u>	\$0	<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,900	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$6,960	The total Joe would pay is	\$1,700	The total Mia would pay is	\$2,800

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

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: [UHC Civil Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج داخل مخلص المزايما والتغطية هنا. (Summary of Benefits and Coverage, SBC)

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage- SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yániliti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shòqdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béesh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).