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 refer to the policy or plan document at https://hrportal.ehr.com/travelers/ or by calling 1-800-441-4378. 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 or call 1-800-441-4378 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network Providers. **$800**/individual or **$1,600**/family. For Out-of- Network Providers **$1,600**/individual or **$3,200**/family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. A copayment or coinsurance may apply. This plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov.
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific services
What is the out-of-pocket limit for this plan?	For Network Providers: **$**3,9**00**/individual **$**7,**800**/family per year. For Out-of-Network Providers: **$7,800**/individual or $**15,600** /family per year. For Prescription Drugs: **$2,900**/individual or **$5,800**/family per year.	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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification, Prescription Drug coinsurance, and certain weight loss and specialty pharmacy drugs.	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.myuhc.com or call 1-866-679-0947 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.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information[1]
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 Copay /visit Deductible does not apply	30% Coinsurance	Virtual Visits (Telehealth) benefits available.
	Specialist visit	$50 Copay /visit Deductible does not apply	30% Coinsurance	
	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)	10% Coinsurance Deductible does not apply for blood work	30% Coinsurance	Prior Authorization required for out of network Sleep Studies or penalty of $500 applies.
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	30% Coinsurance	Prior Authorization required for out of network or penalty of $500 applies.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs Retail (30-day supply) Retail/Mail 90-day supply*	 $13 Copay $26 Copay	See Limitations & Exclusions	If you fill a prescription at an out of network pharmacy but had access to a network pharmacy, you will be reimbursed for the negotiated pharmacy cost minus the applicable in-network Coinsurance. If you did not have access to a network pharmacy, the in-network Coinsurance will apply. Specialty drugs must be filled by CVS Specialty. Participation in the PrudentRx Copay Program will determine what you will pay. Pre-authorization required for certain drugs. *90-day supply: CVS retail or CVS Caremark mail order pharmacies ONLY.
	Preferred brand Drugs Retail (30-day supply) Retail/Mail 90-day supply*	20% Coinsurance $55 min, $190 max $110 min, $380 max		
	Non-preferred brand drugs Retail (30-day supply) Retail/Mail 90-day supply*	40% Coinsurance $55 min, $190 max $110 min, $380 max		
	Specialty drugs (30-day supply)	$0 Copay if participating with PrudentRx; 30% Coinsurance if not participating with PrudentRx		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	30% Coinsurance	Employee initiated pre-authorization required for certain surgical procedures Out of Network or coverage reduced by $500.
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information[1]
		In-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	$225 Copay /visit Deductible does not apply	Covered as In-Network	If admitted, the ER copay is waived.
	Emergency medical transportation	10% Coinsurance	Covered as In-Network	Employee initiated pre-authorization required for Non-emergent ambulance out of network or coverage reduced by $500.
	Urgent care	$50 Copay /visit Deductible does not apply	30% Coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	30% Coinsurance	Employee initiated pre-authorization required for out of network stay or coverage reduced by $500.
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 Copay /visit Deductible does not apply	30% Coinsurance	Employee initiated pre-authorization for Applied Behavioral Analysis (ABA) and certain outpatient services required or coverage reduced by $500. Virtual Visits (Telehealth) benefits available.
	Inpatient services	10% Coinsurance	30% Coinsurance	Employee initiated pre-authorization required for out of network stay or coverage reduced by $500. Coverage for Applied Behavioral Analysis (ABA) treatment is subject to pre-authorization.
If you are pregnant	Office visits	$50 Copay /initial visit only. Deductible does not apply to initial visit.	30% Coinsurance	Employee initiated pre-authorization required for Out of out of network inpatient stays that exceed 48 hours for vaginal delivery or 96 hours for cesarean or coverage reduced by $500. 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	10% Coinsurance	30% Coinsurance	
	Childbirth/delivery facility services	10% Coinsurance	30% Coinsurance	

[1]For more information about limitations and exceptions, see the plan or policy documents at myuhc.com/travelers and the Prescription Drug Overview Page on myHR. After you enroll visit the UHC mobile app or www.myuhc.com website.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information[1]
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	30% Coinsurance	60 visits per plan year. Employee initiated pre-authorization required out of network or coverage reduced by $500. Physical and Occupational Therapy combined 60 visits per plan year. Speech Therapy 60 visits per plan year.
	Rehabilitation services	$40 Copay /visit Deductible does not apply	30% Coinsurance	
	Habilitation services	$40 Copay /visit Deductible does not apply	30% Coinsurance	
	Skilled nursing care	10% Coinsurance	30% Coinsurance	60 days per plan year. Employee initiated pre-authorization required out of network for Skilled Nursing or coverage reduced by $500.
	Durable medical equipment	10% Coinsurance	30% Coinsurance	Employee initiated pre-authorization required out of network for DME devices (Purchase or cumulative rental) or coverage reduced by $500.
	Hospice services	10% Coinsurance	30% Coinsurance	180 days per lifetime. Employee initiated pre-authorization required out of network for Hospice Inpatient or coverage reduced by $500.
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	1 routine vision exam, in Doctor's office, including refraction, per plan year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check- up	Not covered	Not covered	None

[1]For more information about limitations and exceptions, see the plan or policy documents at myuhc.com/travelers and the Prescription Drug Overview Page on myHR. After you enroll visit the UHC mobile app or www.myuhc.com website.

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.)		
• Blood pressure monitoring devices • Child dental check-up • Child vision glasses • Cosmetic Surgery	• Hearing aids for adults (age 19 and older) • Long-term care • Modifications to your home, vehicle and/or the workplace, including vehicle ramps and lifts	• Non-emergency care when traveling outside the U.S. • Private-duty nursing
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric Surgery (in network only) • Chiropractic care	• Dental Care (accident or medical treatment only) • Fertility treatment ($20,000/Lifetime)	• Hearing aids for children under age 19 • Routine foot care • Routine eye care

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 https://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 planfor 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: 1-866-679-0947 or visit https://www.myuhc.com. Employee Benefits Security Administration at 1-866-444-3272 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? No

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 1-866-679-0947.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-679-0947. Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-679-0947.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-679-0947.

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	$800.00
Specialist copayment	$50.00
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$800.00
Copayments	$50.00
Coinsurance	$1,200.00
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	**$2,110.00**

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

The plan's overall deductible	$800.00
Specialist copayment	$50.00
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment visit *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$800.00
Copayments	$600.00
Coinsurance	$600.00
What isn't covered	
Limits or exclusions	$20.00
The total Joe would pay is	**$2,020.00**

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

The plan's overall deductible	$800.00
Specialist copayment	$50.00
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$800.00
Copayments	$500.00
Coinsurance	$100.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$1,400.00**

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