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, visit www.hfbenefits.com or call 1-866-219-1592. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.dol.gov/ebsa/healthreform/ or call 1-866-219-1592 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000/Individual or $3,000/Family **In Network - Platinum** $1,600/Individual or $4,800/Family **In Network - UHC** Out-Of-Network - Not Covered	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 primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes; $400 for failure to pre-certify Inpatient admission, Dialysis, admission to Extended Care Facility or Physical Therapy with MMS at 1-800-625-6834.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. Preauthorization is required for Inpatient Hospital admissions, gender reassignment, Dialysis, admission to Extended Care Facility or Physical Therapy or an additional **$400** deductible shall be applied before the Plan benefits are determined. Benefits reduced to 50% if not medically necessary.
What is the out-of-pocket limit for this plan?	For network providers $6,350 Individual/$12,700 Family; Out-of-Network - Not Covered	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, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.hfbenefits.com.** For information outside of the	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

Important Questions	Answers	Why This Matters:
	Access Direct Platinum service area, visit United Healthcare at **www.hfbenefits.com** or call HealthFirst at 1-866-219-1592.	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 permission from this plan.

 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	$30 copay/visit or 20% for other services in physician office – **Platinum**; 30% coinsurance – **UHC**	Not Covered	Copay applies to Office Visit Only.
	Specialist visit	$30 copay/visit – **Platinum**; 30% coinsurance – **UHC**	Not Covered	Copay applies to Office Visit Only.
	Preventive care/screening/ immunization	100%; deductible waived	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)	100%, if medically necessary – **CPL in Platinum**; 20% coinsurance – **Other services Platinum**; 30% coinsurance – **UHC**	Not Covered	CPL Access Direct Platinum - Covered at 100%, if medically necessary.
	Imaging (CT/PET scans, MRIs)	20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **https://cerpassrx.com/members-page/** or by calling CerpassRx (844) 636-7506	Generic drugs (Tier 1)	$15 copay/**30-day retail**; $37.50 copay/**90-day retail**; $45 copay/**mail order**		Covers up to a 30-day supply (retail prescription); 90-day supply (select 90-day retail or mail order prescription).
	Preferred brand drugs (Tier 2)	$60 copay/**30-day retail**; $150 copay/**90-day retail**; $180 copay/**mail order**		
	Non-preferred brand drugs (Tier 3)	$100 copay/**30-day retail**; $250 copay/**90-day retail**; $300 copay/**mail order**		
	Specialty drugs (Tier 4)	$125/**30-day retail** Not Covered/**90-day retail**; Not Covered/**mail order**		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	None.
	Physician/surgeon fees	20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	None.
If you need immediate medical attention	Emergency room care	$250 copay/visit – True Emergency – **Platinum & UHC** 20% coinsurance – NOT True Emergency – **Platinum**; 30% coinsurance – NOT True Emergency – **UHC**	$250 copay/visit True Emergency; Not Covered if NOT True Emergency	Copay only applies to other In-Network and Out-of-Network if TRUE Emergency.
	Emergency medical transportation	20% coinsurance – **Platinum;** 30% coinsurance – **UHC**	30% coinsurance True Emergency; Not Covered if NOT True Emergency	Air ambulance is limited to a total benefit of $25,000.00 annually. Chartered air flights are excluded.
	Urgent care	$30 copay/visit – **Platinum**; 30% coinsurance – **UHC**	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	Services must have Preauthorization at 1-800-625-6834.
	Physician/surgeon fees	20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	None.

If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit – **Platinum**; 30% coinsurance – **UHC**	Not Covered	Inpatient services must have Preauthorization at 1-800-625-6834.
	Inpatient services	20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	
If you are pregnant	Office visits	Initial Office Visit – 100% after $30 copay; 20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Services must have Preauthorization at 1-800-625-6834 for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.
	Childbirth/delivery professional services	20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	
	Childbirth/delivery facility services	20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	None.
	Rehabilitation services	20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	Inpatient services or outpatient Physical Therapy must have Preauthorization at 1-800-625-6834.
	Habilitation services	20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	
	Skilled nursing care	20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	Inpatient services must have Preauthorization at 1-800-625-6834.
	Durable medical equipment	20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	None.
	Hospice services	20% coinsurance – **Platinum**; 30% coinsurance – **UHC**	Not Covered	None.
If your child needs dental or eye care	Children's eye exam	As defined under Preventive	Not covered	Only as defined under Preventive
	Children's glasses	Not Covered	Not covered	Not Covered
	Children's dental check-up	Not Covered	Not covered	Not Covered

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.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Acupuncture
- Bariatric surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Hearing Aids
- Routine eye care (Adult)
- Routine Foot Care
- Weight loss programs
- Chiropractic care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

N/A

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-826-9781.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-826-9781.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-826-9781.]

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	$1000
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1000
Copayments	$120
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,660**

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

The plan's overall deductible	$1000
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$1,000
Copayments	$1,545
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,973**

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

The plan's overall deductible	$1000
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$859
Copayments	$90
Coinsurance	$215
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,164**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: HealthFirst 1-866-219-1592.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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