



2026 Ben E. Keith Company Annual Notices

The Ben E. Keith Company Welfare Benefit Plan 502 and Retirement Plan 001 provides coverage and benefits that comply with applicable federal and state laws. Several of those laws require that we provide you with a summary of your rights each year.

These Notices are included in the following pages:

2026 Medicare Part D Prescription Drug Notices	Pages 2-3
Women's Health and Cancer Rights	Page 4
Newborns' and Mothers' Health Protection	Page 4
HIPAA Special Enrollment Rights	Page 4
Children's Health Insurance Program (CHIP)	Page 5
Summary Annual Report for the Company Welfare Benefit Plan	Page 7
Summary Annual Report for the Retirement Savings Plan	Page 8

We're also reminding you of other important Notices you have already received or that are contained in this document, including:

Continuation Coverage Rights under COBRA	Page 6
HIPAA Privacy and Security	Page 6
Social Security Numbers of Family Members	Page 6
About the Summaries of Benefits and Coverage	Page 6
UHC Summaries of Benefits and Coverage	Page 9-20

Please review this information and keep it with your other important benefits communications. This information is always available in the **Resources > Plan documents & policies** section of bek.family, Ben E. Keith Company benefits website.

For more information, contact the Corporate Benefits Team at benefits@benekeith.com.

IMPORTANT INFORMATION ABOUT YOUR BEN E. KEITH PRESCRIPTION DRUG COVERAGE AND MEDICARE

2026 NOTICE OF CREDITABLE COVERAGE: BEK PPO MEDICAL PLAN

Please read this Notice carefully, as this Notice has information about prescription drug coverage under the Ben E. Keith PPO Medical Plan (the "BEK PPO Medical Plan") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this Notice.

There are two important things you need to know about BEK PPO Medical Plan coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Ben E. Keith has determined that the prescription drug coverage offered by the BEK PPO Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because the BEK PPO Medical Plan coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your BEK PPO Medical Plan creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Company coverage will not be affected. For most persons covered under the BEK PPO Medical Plan, the BEK PPO Medical Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about which plan pays first and which plan pays second, see the Ben E. Keith Company Summary Plan Description (SPD) or contact Medicare.

If you decide to join a Medicare drug plan and drop your current PPO coverage, you may be able to re-enroll in a Ben E. Keith medical plan during a future Annual Enrollment or within 31 calendar days following a qualified life event.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your BEK PPO Medical Plan coverage and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Review the Ben E. Keith Company Summary Plan Description (SPD) or contact the Corporate Benefits Team at benefits@benekeith.com.

Note: You'll receive this Notice each year and if your medical coverage changes. You can find a copy of this Notice any time in the **Resources** section of bek.family.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit medicare.gov.
- Call your State Health Insurance Assistance Program for personalized help. Find your state's number on the inside back cover of your copy of the "Medicare & You" handbook.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security at socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

IMPORTANT! Keep this 2026 Notice of Creditable Coverage. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this Notice when you join to show whether you maintained creditable coverage and, therefore, whether or not you must pay a higher premium (a penalty).

Date of this Notice: October 1, 2025

Name of Entity: Ben E. Keith Company

Corporate Benefits Team: benefits@benekeith.com

2026 NOTICE OF CREDITABLE COVERAGE: BEK HSA MEDICAL PLAN

Please read this Notice carefully, as this Notice has information about prescription drug coverage under the Ben E. Keith Health Savings Account Medical Plan (the “BEK HSA Medical Plan”) and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this Notice.

There are two important things you need to know about BEK HSA Medical Plan coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Ben E. Keith has determined that the prescription drug coverage offered by the BEK HSA Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because the BEK HSA Medical Plan coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your BEK HSA Medical Plan creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Company coverage will not be affected. For most persons covered under the BEK HSA Medical Plan, the BEK HSA Medical Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about which plan pays first and which plan pays second, see the Ben E. Keith Company Summary Plan Description (SPD) or contact Medicare.

If you decide to join a Medicare drug plan and drop your current HSA coverage, you may be able to re-enroll in a Ben E. Keith medical plan during a future Annual Enrollment or within 31 calendar days following a qualified life event.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your BEK HSA Medical Plan coverage and don’t join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Review the Ben E. Keith Company Summary Plan Description (SPD) or contact the Corporate Benefits Team at benefits@benekeith.com.

Note: You’ll receive this Notice each year and if your medical coverage changes. You can find a copy of this Notice any time in the **Resources** section of bek.family.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit medicare.gov.
- Call your State Health Insurance Assistance Program for personalized help. Find your state’s number on the inside back cover of your copy of the “Medicare & You” handbook.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security at socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

IMPORTANT! Keep this 2026 Notice of Creditable Coverage. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this Notice when you join to show whether you maintained creditable coverage and, therefore, whether or not you must pay a higher premium (a penalty).

Date of this Notice: October 1, 2025

Name of Entity: Ben E. Keith Company

Corporate Benefits Team: benefits@benekeith.com

WOMEN'S HEALTH AND CANCER RIGHTS

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema.

This coverage will be subject to the provisions, limitations, exclusions, deductibles and coinsurance that apply to other medical and surgical benefits provided under the Ben E. Keith medical option in which you're enrolled. For more information, refer to your Summary Plan Description (SPD) in the **Resources > Plan documents & policies** section of bek.family or call UnitedHealthcare at 1-844-587-8503.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In addition, plans may not require that a provider obtain prior authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

For more information, refer to your Summary Plan Description (SPD) in the **Resources > Plan documents & policies** section of bek.family or call UnitedHealthcare at 1-844-587-8503.

HIPAA SPECIAL ENROLLMENT RIGHTS

If you're declining enrollment in a Ben E. Keith medical plan for yourself or your eligible family members (your spouse and children) because you have other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible family members in a Ben E. Keith medical plan if you or your family member(s) lose eligibility for that other coverage (or if the employer stops contributing toward your or your family members' other coverage). However, **you must request enrollment within 31 calendar days** after your or your family members' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new family member as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible family members in a Ben E. Keith medical option, provided you are eligible. However, **you must request enrollment within 31 calendar days** after the marriage, birth, adoption or placement for adoption.

If coverage is lost under your State Medicaid or a Children's Health Insurance Program (CHIP) plan, or you become eligible for premium assistance under your State Medicaid or CHIP plan, you may be able to enroll yourself and your eligible family members in a Ben E. Keith medical plan. **You must request enrollment within 60 calendar days** of the date of the event. (See the "Children's Health Insurance Program (CHIP)" notice for more information.)

To request special enrollment, contact your HR Manager or Office Manager or contact the Corporate Benefits Team at benefits@benekeith.com.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial 1-877-KIDS NOW or visit insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Ben E. Keith medical plan, we must allow you to enroll if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 calendar days of being determined eligible for premium assistance.

If you have questions about enrolling in a Ben E. Keith medical plan, contact your HR Manager or Office Manager, or contact the Corporate Benefits Team at benefits@benekeith.com. You can also contact the Department of Labor at askebsa.dol.gov or call 1-866-444-EBSA (3272). If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your state for more information on eligibility.

Alabama – Medicaid

<http://myalhipp.com/>

1-855-692-5447

Kansas – Medicaid

<http://www.kancare.ks.gov>

1-800-792-4884

HIPP phone: 1-800-967-4660

Arkansas – Medicaid

<http://myarhipp.com/>

1-855-MyARHIPP (855-692-7447)

Louisiana – Medicaid

<http://www.medicaid.la.gov> or <http://www.ldh.la.gov/laipp>

1-888-342-6207 (Medicaid hotline)

1-855-618-5488 (LaHIPP)

Colorado – Medicaid and CHP+

Health First Colorado: <http://www.healthfirstcolorado.com/>

1-800-221-3943/State Relay 711

CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>

1-800-359-1991/State Relay 711

Health Insurance Buy-In: <https://www.mycohibi.com>

1-855-692-6442

Missouri – Medicaid

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

1-573-751-2005

Florida – Medicaid

<https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>

1-877-357-3268

North Carolina – Medicaid

<https://medicaid.ncdhs.gov/>

1-919-855-4100

Georgia – Medicaid

<https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

1-678-564-1162, Press 1

CHIPRA: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>

1-678-564-1162, Press 2

Oklahoma – Medicaid and CHIP

<http://www.insureoklahoma.org>

1-888-365-3742

South Carolina – Medicaid

<https://www.scdhhs.gov>

1-888-549-0820

Texas – Medicaid

<https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>

1-800-440-0493

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

or

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, menu option 4, Ext. 61565

IMPORTANT REMINDER: REVIEW NOTICES YOU MAY HAVE ALREADY RECEIVED

CONTINUATION COVERAGE RIGHTS UNDER COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

For more information about your rights and obligations under the Plan and under federal law, review the COBRA Rights Notice that was provided to you when you first became eligible. You can also find information in the Plan's Summary Plan Description (SPD) in the **Resources > Plan documents & policies** section of bek.family or by contacting your HR Manager or Office Manager.

HIPAA PRIVACY AND SECURITY

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own health care information.

The Ben E. Keith Company HIPAA Notice of Privacy Practices explains how the Ben E. Keith Company Welfare Benefit Plan may and may not use and share your protected health information and how you can exercise your health privacy rights. It also explains our obligation to notify you following a breach of unsecured protected health information. We're required to notify you of the availability of this Notice every three years.

For a copy of the most recent Notice, go to the **Resources > Plan documents & policies** section of bek.family or contact the Corporate Benefits Team at benefits@benekeith.com.

SOCIAL SECURITY NUMBERS OF FAMILY MEMBERS

Ben E. Keith is required by law to collect the Social Security number (or other taxpayer identification number) of each family member who enrolls in a Ben E. Keith medical plan and report that information to the Internal Revenue Service each year.

If a family member does not yet have a Social Security number (for example, a newborn child), you can request one from the Social Security Administration by visiting <https://www.ssa.gov/forms/ss-5.pdf>. Applying for a Social Security number is free.

If you have not yet provided the Social Security number (or other taxpayer identification number) for each of your enrolled family members, please add it to your information when enrolling during Annual Enrollment or when requesting coverage for a family member following a qualified status change. If there are delays in getting a Social Security number, please see your HR Manager or Office Manager or contact the Corporate Benefits Team at benefits@benekeith.com.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Ben E. Keith is required to provide you with an SBC for each medical plan option each year during Open Enrollment. The SBCs describe the benefits available to you, in a prescribed format, so you can easily compare your Ben E. Keith medical options to other plans that may be available to you.

The 2026 SBCs for the BEK PPO Medical Plan and the BEK HSA Medical Plan are included on pages 9-20 of this document. If you have questions about these summaries, or want an additional copy, go to the **Resources > Plan documents & policies** section of bek.family or contact the Corporate Benefits Team at benefits@benekeith.com.



2024 SUMMARY ANNUAL REPORT FOR BEN E. KEITH COMPANY WELFARE BENEFIT PLAN

This is a summary of the annual report of the Ben E. Keith Company Welfare Benefit Plan, EIN 75-0372230, Plan No. 502, for the period January 1, 2024 through December 31, 2024. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Ben E. Keith Company has committed itself to pay certain self-insured medical, stop loss and short-term disability claims incurred under the terms of the Plan.

Insurance Information

The Plan has contracts with Cigna Health and Life Insurance Company and Affiliates (dental); Metropolitan Life Insurance Company (vision); Blue Cross Blue Shield of Alabama (BCBS medical); and Lincoln National Life Insurance Company (employee, spouse and child life/AD&D) to pay medical, dental, vision and life/AD&D claims incurred under the terms of the Plan. The total premiums paid for the plan year ending December 31, 2024 were \$12,844,601.

Because they are so called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending December 31, 2024, the premiums paid under such "experience-rated" contracts were \$4,447,426 and the total of all benefit claims paid under these contracts during the plan year was \$3,438,765.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The report includes insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write Ben E. Keith Company at 601 East 7th Street, Fort Worth, TX 76102, or contact the Corporate Benefits Team at benefits@benekeith.com.

You also have the legally protected right to examine the annual report at the main office of the plan (Ben E. Keith Company, 601 East 7th Street, Fort Worth, TX 76102) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to:

Public Disclosure Room N1513
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210



2024 SUMMARY ANNUAL REPORT BEN E. KEITH RETIREMENT SAVINGS PLAN

This is a summary of the annual report for the Ben E. Keith Retirement Savings Plan (Employer Identification Number 75-0372230, Plan Number 002) for the plan year July 1, 2023 through June 30, 2024. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

Benefits under the Plan are provided by a trust fund. Plan expenses were \$23,483,271. These expenses included \$403,388 in administrative expenses and \$22,819,413 in benefits paid to participants and beneficiaries, and \$260,470 in other expenses. A total of 7,473 persons were participants in or beneficiaries of the Plan at the end of the Plan year, although not all of these persons had yet earned the right to receive benefits.

The value of Plan assets, after subtracting liabilities of the Plan, was \$400,527,407 as of the end of the plan year, compared to \$313,321,603 as of the beginning of the Plan year. During the Plan year, the Plan experienced a change in its net assets of \$87,205,804. This change includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the Plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The Plan had total income of \$110,689,075, including employer contributions of \$29,681,351, employee contributions of \$32,247,521, other contributions/other income of \$3,670,515, and earnings from investments of \$45,089,688.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, any part thereof, on request. The report includes an accountant's report, financial information and information on payments to service providers, assets held for investment, and information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the Plan participates.

To obtain a copy of the full annual report, or any part thereof, write the Ben E. Keith Company at 601 East 7th Street, Fort Worth, TX 76102, or call 1-817-877-5700.

You also have the right to receive from the Plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the Plan administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the Plan: 601 East 7th Street, Fort Worth, TX 76102, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to:

Public Disclosure Room N-1513
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210



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 1-844-587-8503 or visit welcometouhc.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 healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	<u>Network: \$1,500</u> Individual / <u>\$4,500</u> Family <u>Out-of-Network: \$3,000</u> Individual / <u>\$9,000</u> Family Per calendar 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> .
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Preventive care</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 services at www.healthcare.gov/coverage/preventive-care-benefits/ .
<u>Are there other deductibles for specific services?</u>	Yes, Prescription drugs - <u>\$100</u> per person. <u>\$300</u> per family. There are no other specific <u>deductibles</u> .	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.
<u>What is the out-of-pocket limit for this plan?</u>	<u>Network: \$4,000</u> Individual / <u>\$8,000</u> Family <u>Out-of-Network: \$8,000</u> Individual / <u>\$16,000</u> Family Per calendar 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.
<u>What is not included in the out-of-pocket limit?</u>	<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> .
<u>Will you pay less if you use a network provider?</u>	Yes. See myuhc.com or call 1-844-587-8503 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 lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a referral to see a specialist?</u>	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	\$35 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	Virtual visits – \$20 copay per visit, by a Designated Virtual <u>Network Provider</u> , <u>deductible</u> does not apply. *Cost share applies to any other Telehealth service based on provider type. No virtual coverage <u>out-of-network</u> . If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
	<u>Specialist</u> visit	\$50 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</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)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: \$10 copay Mail-Order: \$20 copay	Not Covered	<u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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.
	Tier 2 – Your Mid-Range Cost Option	Retail: \$35 copay Mail-Order: \$70 copay	Not Covered	If you use a non- <u>network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . CVS pharmacies are not covered.
	Tier 3 – Your Mid-Range Cost Option	Retail: \$60 copay Mail-Order: \$120 copay	Not Covered	Certain preventive medications (including certain contraceptives) are covered at No Charge.
	Tier 4 – Your Highest Cost Option	Retail: 25% coinsurance (\$100 min copay/\$250 max)	Not Applicable	See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.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)	
		Mail-order: 25% coinsurance (\$200 min copay/\$500 max copay)		You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> per visit, then 20% <u>coinsurance</u>	\$200 <u>copay</u> per visit, then 20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	*20% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<u>Urgent care</u>	\$75 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	\$300 inpatient confinement <u>deductible</u> applies <u>out-of-network</u> prior to the overall deductible. <u>Prauthorization</u> is required <u>out-of-network</u> or a \$500 penalty applies.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	PCP: \$35 copay per visit, deductible does not apply	50% <u>coinsurance</u>	<u>Network</u> Partial hospitalization/intensive outpatient treatment: 20% <u>coinsurance</u> .
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you are pregnant	Office visits	No Charge	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

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	20% coinsurance	50% coinsurance	\$300 inpatient confinement deductible applies out-of-network prior to the overall deductible.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or a \$500 penalty applies.
	<u>Rehabilitation services</u>	20% coinsurance	50% coinsurance	Outpatient rehabilitation services are unlimited per calendar year.
	<u>Habilitative services</u>	20% coinsurance	50% coinsurance	Limits per calendar year: physical, speech, occupational: unlimited.
	<u>Skilled nursing care</u>	20% coinsurance	50% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network or a \$500 penalty applies.
	<u>Durable medical equipment</u>	20% coinsurance	50% coinsurance	None
	<u>Hospice services</u>	No Charge	No Charge	Limited to 180 days per calendar year. Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or a \$500 penalty applies.
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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

• Acupuncture	• Dental care	• Long-term care	• Routine eye care	• Weight loss programs
• Bariatric surgery	• Glasses	• Non-emergency care when travelling outside the U.S.	• Routine foot care – Except as covered for Diabetes	
• Cosmetic surgery	• Hearing aids			

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

• Chiropractic (Manipulative care) – 20 visits per calendar year	• Infertility treatment	• Private duty nursing
------------------------------------------------------------------	-------------------------	------------------------

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 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 may help you file your appeal. Contact 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? 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.

—————*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 <u>deductible</u>	\$1,500
■ <u>Specialist copay</u>	\$50
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost **\$12,700**

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles*</u>	\$1,500
<u>Copayments</u>	\$35
<u>Coinsurance</u>	\$3,841

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$5,076

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$1,500
■ <u>Specialist copay</u>	\$50
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost **\$5,600**

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles*</u>	\$1,500
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$1,142

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$3,362

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$1,500
■ <u>Specialist copay</u>	\$50
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost **\$2,800**

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles*</u>	\$1,000
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$420

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$2,320

*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 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 1-844-587-8503 or visit welcometouhc.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 healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	<u>Network</u> : \$3,400 Individual / \$6,800 Family <u>Out-of-Network</u> : \$6,800 Individual / \$13,600 Family Per calendar 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> .
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Preventive care</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 services at www.healthcare.gov/coverage/preventive-care-benefits/ .
<u>Are there other deductibles for specific services?</u>	No	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	<u>Network</u> : \$6,550 Individual / \$13,100 Family <u>Out-of-Network</u> : \$13,100 Individual / \$26,200 Family Per calendar 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.
<u>What is not included in the out-of-pocket limit?</u>	<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> .
<u>Will you pay less if you use a network provider?</u>	Yes. See myuhc.com or call 1-844-587-8503 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 lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a referral to see a specialist?</u>	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)	Non-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	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Virtual visits - 0% <u>coinsurance</u> by a Designated Virtual Network Provider. *Cost share applies to any other Telehealth service based on provider type. No virtual coverage <u>out-of-network</u> .
	<u>Specialist</u> visit	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<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)	20% <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)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: 20% <u>coinsurance</u> (\$10 minimum copay) Mail-Order: 20% <u>coinsurance</u> (\$20 minimum copay)	Not Covered	<u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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.
	Tier 2 – Your Mid-Range Cost Option	Retail: 20% <u>coinsurance</u> (\$35 minimum copay) Mail-Order: 20% <u>coinsurance</u> (\$70 minimum copay)	Not Covered	If you use an <u>out-of-network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . CVS pharmacies are not covered.
	Tier 3 – Your Mid-Range Cost Option	Retail: 20% <u>coinsurance</u> (\$60 minimum copay) Mail-Order: 20% <u>coinsurance</u> (\$120 minimum copay)	Not Covered	Certain preventive medications (including certain contraceptives) 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.
	Tier 4 – Your Highest Cost Option	Retail: 20% <u>coinsurance</u> (\$100 minimum copay) Mail-Order: 20%	Not Applicable	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> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
		<u>coinsurance</u> (\$200 minimum copay)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	*20% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	*20% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<u>Urgent care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
If you are pregnant	Office visits	No Charge	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Inpatient preauthorization applies <u>out-of-network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of <u>allowed amount</u> .
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 visits per calendar year. Preauthorization is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Outpatient rehabilitation services are unlimited per calendar year.
	<u>Habilitative services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limits per calendar year: Physical, Speech, Occupational: Unlimited.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	Durable medical equipment	20% coinsurance	50% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. <u>Preauthorization</u> is required <u>out-of-network</u> for DME over \$1,000 or no coverage.
	Hospice services	0% coinsurance	0% coinsurance	<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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

• Acupuncture	• Dental care	• Long-term care	• Routine eye care	• Weight loss programs
• Bariatric surgery	• Glasses	• Non-emergency care when travelling outside the U.S.	• Routine foot care – Except as covered for Diabetes	
• Cosmetic surgery	• Hearing aids			

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

• Chiropractic (Manipulative care) –20 visits per calendar year	• Infertility treatment	• Private duty nursing
-----------------------------------------------------------------	-------------------------	------------------------

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 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 may help you file your appeal. Contact 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? 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.

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 <u>plan's</u> overall <u>deductible</u>	\$3,400
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ <u>Hospital (facility)</u> <u>coinsurance</u>	20%
■ <u>Other</u> <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700
--------------------	----------

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,400

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$5,860

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,400
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ <u>Hospital (facility)</u> <u>coinsurance</u>	20%
■ <u>Other</u> <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
--------------------	---------

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$600

What isn't covered

Limits or exclusions	\$0
The total Joe would pay is	\$4,000

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,400
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ <u>Hospital (facility)</u> <u>coinsurance</u>	20%
■ <u>Other</u> <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
--------------------	---------

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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

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

Notice of Nondiscrimination

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

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.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-734-7670 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 11-866-734-7670 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意:如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-866-734-7670 (TTY:711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-734-7670 (TTY: 711).

Arabic: انتبه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 7670-734-866-1 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-734-7670 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-734-7670 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-734-7670 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગજુ શાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુદ્ધ ઉપલબ્ધ છે. 1-866-734-7670 પર કોલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-734-7670 (TTY: 711).

Hindi: ધ્યાન દાન: અगर આપકી ભાષા હિંદી હૈ, તો આપકે લિલા ભાષા સહાયતા સેવાએ નિઃશુદ્ધ ઉપલબ્ધ હોય। 1-866-734-7670 (TTY: 711) પર કોલ કરો।

Laotian: ໄດ້ຊາບ:ຖ້າວ່າທ່ານເວົ້າພາສາລາວ,ກາງບໍລິການຊ່ວຍເຫຼື່ອ,ອດ້າງພາສາ,ດ້ານບໍ່ເຊິ່ງອ່າ,ແມ່ນມີພົມໃຫ້ທ່ານ.ໄດ້ 1-866-734-7670 (TTY:711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-734-7670 (телефон: .)711

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-734-7670 (TTY:711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-734-7670 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyorsanız, dil yardım hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-866-734-7670 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-734-7670 (TTY: 711).

Japanese: 注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-866-734-7670 (TTY: 711)まで、お電話にてご連絡ください。