



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 AGBenefits Advisor 800-397-9249 or go to AGBenefits.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 AGBenefits.com or call 800-397-9249 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For in-network \$3,500 individual/ \$7,000 family; For out-of-network \$7,000 individual/ \$14,000 family Doesn't apply to preventive care	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, screenings and immunizations are covered at no charge.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For in-network providers , \$4,500 individual/ \$9,000 family (includes deductible); For out-of-network providers , \$9,000 individual/ \$18,000 family (includes deductible)	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of 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 ?	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 myuhc.com or call AGBenefits Advisor at 800-397-9249 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	UHC Preferred Provider: 20% co-insurance All other providers: 40% co-insurance	40% co-insurance	-----none-----
	Specialist visit	UHC Preferred Provider: 20% co-insurance All other providers: 40% co-insurance	40% co-insurance	-----none-----
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Non-hospital labs: 20% co-insurance All other labs: 40% co-insurance	40% co-insurance	-----none-----
	Imaging (CT/PET scans, MRIs)	Non-hospital imaging: 20% co-insurance All other imaging: 40% co-insurance	40% co-insurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at AGBenefits.com	Tier 1	20% co-insurance	20% co-insurance	-----none-----
	Tier 2	25% co-insurance	25% co-insurance	Certain brand-name drugs that have lower cost alternatives are excluded. If you purchase excluded prescriptions, the cost will not apply to your deductible or out-of-pocket maximum.
	Tier 3	50% co-insurance	50% co-insurance	You may receive a non-preferred brand drug at the preferred brand drug co-insurance, if approved under an appeal.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	UHC Preferred Provider: 20% co-insurance	40% co-insurance	-----none-----

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)	
		All other providers: 40% co-insurance		
	Physician/surgeon fees	UHC Preferred Provider: 20% co-insurance All other providers: 40% co-insurance	40% co-insurance	
If you need immediate medical attention	Emergency room care	20% co-insurance	20% co-insurance	No coverage of physician/surgeon fees for non-emergency use
	Emergency medical transportation	20% co-insurance	20% co-insurance	-----none-----
	Urgent care	20% co-insurance	20% co-insurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	-----none-----
	Physician/surgeon fees	20% co-insurance	40% co-insurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance	40% co-insurance	-----none-----
	Inpatient services	20% co-insurance	40% co-insurance	-----none-----
If you are pregnant	Office visits	UHC Preferred Provider: 20% co-insurance All other providers: 40% co-insurance	40% co-insurance	Cost Sharing does not apply for preventive services. Depending on the type of services, a deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	UHC Preferred Provider: 20% co-insurance All other providers: 40% co-insurance	40% co-insurance	-----none-----
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Limited to 100 visits per year
	Rehabilitation services	20% co-insurance	40% co-insurance	Outpatient cardiac rehabilitation limited to 36 visits per year Outpatient Therapy limited to 60 visits per year
	Habilitation services	20% co-insurance	40% co-insurance	Limited to 60 visits per year
	Skilled nursing care	20% co-insurance	40% co-insurance	Limited to 180 visits per year

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)	
	Durable medical equipment	20% co-insurance	40% co-insurance	-----none-----
	Hospice services	20% co-insurance	40% co-insurance	Limited to 360 days per year
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Excluded service
	Children's glasses	Not covered	Not covered	Excluded service
	Children's dental check-up	Not covered	Not covered	Excluded service

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 | • Private duty nursing | • |
| • Cosmetic surgery | • Routine foot care | |
| • Weight loss programs | • Routine eye care (adult) | |

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

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|--|------------------|---------------------|
| • Bariatric surgery | • Long-term care | • Chiropractic care |
| • Non-emergency care when traveling outside the U.S. | | • Hearing aids |

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: Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, 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: AGBenefits Advisor at 800-397-9249 or AGBenefits.com or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-397-9249.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800-397-9249.

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	\$3,500
■ Specialist co-insurance	20%
■ Hospital (facility) co-insurance	20%
■ Other co-insurance	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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$1,840
What isn't covered	
Limits or exclusions	\$100
The total Peg would pay is	\$4,600

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$3,500
■ Specialist co-insurance	20%
■ Hospital (facility) co-insurance	20%
■ Other co-insurance	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	\$7,500
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$100
The total Joe would pay is	\$4,400

Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,500
■ Specialist co-insurance	20%
■ Hospital (facility) co-insurance	20%
■ Other co-insurance	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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900