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 **$700** individual/**$2,100** family; For out-of-network **$1,400** individual/**$4,200** 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?	**Medical:** For in-network **providers**, **$2,700** individual / **$8,100** family (includes **deductible**); For out-of-network **providers**, **$5,400** individual / **$16,200** family (includes **deductible**) **Prescription Drugs**: **$1,500** individual/**$2,000** family	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?	**Copayments** on 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 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	No.	You can see the **specialist** you choose without a **referral**.

see a specialist?		

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 co-pay/visit	40% co-insurance	----------none----------
	Specialist visit	$50 co-pay/visit	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	Minimum $10 (retail) / Minimum $20 (Mail order)
	Tier 2	30% co-insurance	30% co-insurance	Minimum $30 (retail) / Minimum $60 (Mail order) You may receive a non-preferred brand drug at preferred brand drug co-insurance and minimum, if approved under an appeal.
	Tier 3	60% co-insurance	60% co-insurance	Minimum $45 (retail) / Minimum $90 (Mail order) You may receive a non-preferred brand drug at preferred brand drug co-insurance and minimum, if approved under an appeal.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	UHC Preferred Provider: 20% co-insurance All other providers: 40% 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)	
	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	$200 co-pay/visit (waived if admitted), then 20% co-insurance	$200 co-pay/visit (waived if admitted), then 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	$50 co-pay/visit	$50 co-pay/visit	----------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	$30 co-pay	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
	Durable medical equipment	20% co-insurance	40% co-insurance	----------none----------
	Hospice services	20% co-insurance	40% co-insurance	Limited to 360 days 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)	
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
- Cosmetic surgery
- Weight loss programs
- Private duty nursing
- Routine foot care
- Routine eye care (adult)

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

- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Long-term care
- Chiropractic care
- 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	$700
Specialist *Copayment*	$50
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$700
Copayments	$400
Coinsurance	$2,320
What isn't covered	
Limits or exclusions	$80
The total Peg would pay is	**$3,500**

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

The plan's overall deductible	$700
Specialist *Copayment*	$50
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$700
Copayments	$1,100
Coinsurance	$1,120
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$3,000**

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

The plan's overall deductible	$700
Specialist *Copayment*	$50
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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