

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.whuuhc.com or by calling 1-800-782-3740. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/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>	Network: \$5,000 Individual / \$10,000 Family out-of-Network: \$10,000 Individual / \$20,000 Family Per calendar year.	Generally, you must pay all of the costs from providers 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 deductible until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Preventive</u> care is covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <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 deductible. See a list of covered <u>preventive services</u> 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>	Network: \$7,000 Individual / \$14,000 Family out-of-Network: \$20,000 Individual / \$40,000 Family	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</u> limits until the overall family <u>out-of-pocket</u> limit has been met.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, <u>balance-billing</u> charges (unless <u>balance-billing</u> is prohibited), 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</u> limit.
<u>Will you pay less if you use a network provider?</u>	Yes. See https://www.whuuhc.com/welcometouhc/plan-benefits or call 1-800-782-3740 for a list of network providers.	This <u>plan</u> uses a provider <u>Network</u> . You will pay less if you use a provider in the <u>plan's Network</u> . You will pay the most if you use an <u>out-of-Network</u> provider, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>Network</u> provider might use an <u>out-of-Network</u> provider 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	20% coinsurance	45% coinsurance	Virtual visits (Telehealth) - 20% coinsurance by a Designated Virtual Network Provider. No virtual coverage for out-of-Network. Cost shares applies to any other Telehealth service based on provider type.
	Specialist visit	20% coinsurance	45% coinsurance	None
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. 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. Certain services are covered when using out-of-Network Provider. Deductible/ coinsurance may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	Designated Lab: 20% coinsurance Lab: 45% coinsurance X-ray: 20% coinsurance	Lab: 45% coinsurance X-ray: 45% coinsurance	Preadmission required for out-of-Network for certain services or benefit reduces to 50% of allowed. For Designated Network Benefits, lab services must be received by a Designated Diagnostic Provider. Network Benefits are lab services received from a Network provider that is not a Designated Diagnostic Provider.
	Imaging (CT/PET scans, MRIs)	Designated: 20% coinsurance Network: 40% coinsurance	45% coinsurance	Preadmission required for out-of-Network or benefit reduces to 50% of allowed. For Designated Network Benefits, radiology services must be received from a Designated Diagnostic Provider.

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 need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at whyuhc.com/welcometouhc/pharmacy-benefits .	Tier 1 - Your Lowest-Cost Option	Retail: \$10 <u>copay</u> Mail-Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u>	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply . Mail-Order: 90 day supply or Preferred 90 Day Retail Network pharmacy. If you use an out-of-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. <u>Prescription Drug List (PDL)</u> : Advantage. <u>Network</u> : National. Certain preventive medications, zero cost share medications, and Tier 1 contraceptives are covered at No Charge. <u>Copay</u> is per prescription order up to the day supply limit listed above.
	Tier 2 - Your Midrange-Cost Option	Retail: \$35 <u>copay</u> Mail-Order: \$87.50 <u>copay</u>	Retail: \$35 <u>copay</u>	
	Tier 3 - Your Midrange-Cost Option	Retail: \$70 <u>copay</u> Mail-Order: \$175 <u>copay</u>	Retail: \$70 <u>copay</u>	
	Tier 4 - Additional High-Cost Options	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	45% <u>coinsurance</u>	Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	20% <u>coinsurance</u>	45% <u>coinsurance</u>	None
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Urgent care	20% <u>coinsurance</u>	45% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	45% <u>coinsurance</u>	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	20% <u>coinsurance</u>	45% <u>coinsurance</u>	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	45% coinsurance	Network partial hospitalization/intensive outpatient treatment/high intensity outpatient: 20% coinsurance Intensive Behavior Therapy (ABA): 20% coinsurance Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.
	Inpatient services	20% coinsurance	45% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	25% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	45% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% coinsurance	45% coinsurance	Inpatient preauthorization apply for out-of-Network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	45% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed. Limited to 60 visits per calendar year.
	Rehabilitation services	20% coinsurance	45% coinsurance	Limits per calendar year: Physical, Speech, Occupational: 30 visits (combined). Pulmonary: 36 visits; Cardiac: 36 visits.
	Habilitation services	20% coinsurance	45% coinsurance	Preauthorization required for out-of-Network inpatient services or benefit reduces to 50% of allowed. Cost share applies for outpatient services only. Services provided under and limits are combined with Rehabilitation services above.
	Skilled nursing care	20% coinsurance	45% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed. Skilled Nursing Facility is limited to 60 days per calendar year. (combined with Inpatient Rehabilitation)

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% <u>coinsurance</u>	Not Covered	Covers 1 per type of <u>Durable medical equipment</u> (including repair/replace) every 3 years.
	Hospice services	20% <u>coinsurance</u>	45% <u>coinsurance</u>	<u>Preauthorization</u> required for out-of-Network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Eye exam.
	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 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 (Adult/Child)
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Bariatric surgery
- Glasses
- Private-duty nursing
- Cosmetic surgery
- Long-term care
- Routine eye care (Adult/Child)
- Weight loss programs

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

- Chiropractic care-20 visits per calendar year
- Hearing aids
- Infertility treatment - In Vitro services only

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: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration, you may also contact us at 1-800-782-3740 . Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-800-782-3740 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Arkansas Insurance Department at 1-501-371-2640 or 1-800-852-5494 or www.insurance.arkansas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact Arkansas Insurance Department, Consumer Services Division at 855-332-2227 or visit www.insurance.arkansas.gov.

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet the Minimum Value Standards? Yes.

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-782-3740.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-782-3740.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-782-3740.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-782-3740 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-782-3740.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-782-3740.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-782-3740.

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)

■ <u>The plan's overall deductible</u>	\$5,000
■ <u>Specialist coinsurance</u>	20%
■ <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	
Deductible	\$5,000
Copayments	\$10
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,270

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

■ <u>The plan's overall deductible</u>	\$5,000
■ <u>Specialist coinsurance</u>	20%
■ <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	
Deductible	\$1,700
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,700

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

■ <u>The plan's overall deductible</u>	\$5,000
■ <u>Specialist coinsurance</u>	20%
■ <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	
Deductible	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
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.

Health Insurance Premiums and Plan Contribution Breakdown

Regular Employee	Monthly Premium	50% ER Contribution	EE Monthly Resp	Bi-Weekly Payroll Deduction
Employee Only	\$994.83	\$497.42	\$497.42	\$229.58
Employee + Spouse	\$1,989.55	\$994.78	\$994.78	\$459.13
Employee + Child(ren)	\$1,591.72	\$795.86	\$795.86	\$367.32
Family	\$2,686.03	\$1,343.02	\$1,343.02	\$619.85

Tenured Employee	Monthly Premium	70% ER Contribution	EE Monthly Resp	Bi-Weekly Payroll Deduction
Employee Only	\$994.83	\$696.38	\$298.45	\$137.75
Employee + Spouse	\$1,989.55	\$1,392.69	\$596.87	\$275.48
Employee + Child(ren)	\$1,591.72	\$1,114.20	\$477.52	\$220.39
Family	\$2,686.03	\$1,880.22	\$805.81	\$371.91