SEM®

BUILT BETTER

2018
Benefits Guide

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This summary is not a legal document and does not replace or supersede the "Evidence of Coverage", policy, or the Summary Plan Description. Please refer to the Evidence of Coverage/insurance policy/Summary Plan Description for a complete description of the coverage, eligibility criteria, controlling terms, exclusions, limitations, and conditions of coverage.

SEM Products, Inc. reserves the right to terminate, suspend, withdraw, reduce, or modify the benefits described in the Evidence of Coverage/policy/Summary Plan Description in whole or in part, at any time. No statement in this or any other document and no oral representation should be construed as a waiver of this right. This summary is the confidential property of SEM Products, Inc.

A Message to Our Employees

At SEM we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each and every employee makes to our success and so our goal is to provide a broad range of benefits to attract and retain the best employees available. As healthcare costs continue to rise due to inflation and increased government regulations, the cost to provide healthcare coverage has also increased. We are committed to delivering an affordable and competitive benefits package to our employees.

Benefits for You & Your Family

Eligible Employees

SEM is pleased to announce our May 1, 2018 benefits program, which is designed to help you stay healthy, feel secure, and maintain a work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace. Please read the information provided in this guide carefully. For full details about our plans, please refer to the Summary Plan Descriptions. Listed below are the benefits available during open enrollment and as a new hire:

- Medical/Vision Insurance
- Dental Insurance
- Basic Life Insurance
- Voluntary Life Insurance
- Dependent Life Insurance
- Dependent Voluntary Life
- Voluntary Accident Policy

Who is Eligible?

All full-time employees scheduled to work at least 30 hours per week are eligible to participate in our medical plan; all other benefits require 32 hours, unless stated otherwise. Eligible employees may also enroll their legal spouse, domestic partner and dependent children (married or unmarried) up to age 26, unless otherwise noted. A dependent child may be the natural child, stepchild, legally adopted child, child placed for adoption, or other child for whom the employee has permanent legal custody.

When Coverage Begins

Employees and their dependents are eligible for benefits on the first day of the month coinciding with or next following date of hire. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, unless you experience a qualified change in status.

Changing Coverage During the Year

You can change your coverage during the year when you experience a qualified change in status, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage.

The change must be reported to Human Resources within 30 days of the event date. Documentation may be required to verify your change in status. Failure to report the change of status within 30 days of the event will result in having to wait until the next open enrollment period to make your change. The change must be consistent with the event.

For example, if your dependent child no longer meets eligibility requirements, you can drop coverage only for that dependent.

Medical

SEM offers a High Deductible Health Plan (HSA) and a Standard PPO Plan through UnitedHealthcare. Employees will have in-network benefits by using the UHC Providers throughout the United States; employees will have reduced benefits if Providers are utilized outside the UHC Network. To access the website for UnitedHealthcare, go to www.myuhc.com or call 866-873-3903.

BenefitWallet administers our Health Savings Accounts (HSA). The employee's contribution to the HSA is optional. SEM contributes to the HSA; $1,250 for employees with Single Coverage and $2,250 for employees with Covered Dependents. This contribution is distributed in increments during May, August, and November. The amount is prorated for any employees hired during the year once they become eligible for medical coverage.

For more information regarding your HSA, please call 877-472-4200 or go to www.mybenefitwallet.com.

	Medical Plan 1 - HSA		Medical Plan 2 - PPO	
Plan Year 5/1/2018 – 4/30/2019	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Plan Year Deductible				
Individual	$2,000	$10,000	$1,500	$3,000
Family	$4,000	$20,000	$3,000	$6,000
Coinsurance	10%	40%	20%	50%
Maximum Out-of-Pocket**				
Individual	$4,000	$12,500	$6,600	$15,000
Family	$8,000	$25,000	$13,200	$30,000
Physician Office Visit				
Primary Care	Ded., then 10%	Ded., then 40%	$25 Copay	Ded., then 50%
Specialty Care	Ded., then 10%	Ded., then 40%	$50 Copay	Ded., then 50%
Preventive Care	0%	Not Covered	0%	Not Covered
Diagnostic Services				
X-ray and Lab Tests	Ded., then 10%	Ded., then 40%	Ded., then 20%	Ded., then 50%
Advanced Imaging Services (CT Scan, PET Scan, MRI)	Ded., then 10%	Ded., then 40%	Ded., then 20%	Ded., then 50%
Urgent Care Facility	Ded., then 10%	Ded., then 40%	$50 Copay	Ded., then 50%
Emergency Room Facility Charges*	Ded., then 10%	Ded., then 40%	$350 Copay	$350 Copay
Ambulance***	Ded., then 10%	Ded., then 40%	Ded., then 20%	Ded., then 20%
Physicain Services	Ded., then 10%	Ded., then 40%	Ded., then 20%	Ded., then 50%
Inpatient Facility Charges	Ded., then 10%	Ded., then 40%	Ded., then 20%	Ded., then 50%
Outpatient Facility and Surgerical Charges	Ded., then 10%	Ded., then 40%	Ded., then 20%	Ded., then 50%
Mental Health and Substance Abuse				
Inpatient	Ded., then 10%	Ded., then 40%	Ded., then 20%	Ded., then 50%
Outpatient	Ded., then 10%	Ded., then 40%	$50 Copay	Ded., then 50%
Other Services				
Chiropractic (20 visists per year	Ded., then 10%	Ded., then 40%	$25 Copay	Ded., then 50%
Physical Therapy (20 visits per year)	Ded., then 10%	Ded., then 40%	$25 Copay	Ded., then 50%
Home Health (60 visits per year)	Ded., then 10%	Ded., then 40%	Ded., then 20%	Ded., then 50%
Hospice	Ded., then 10%	Ded., then 40%	Ded., then 20%	Ded., then 50%
Telemedicine				
Virtual Visits	$49	N/A	$10 Copay	N/A

*Waived if Admitted

**Includes Coinsurance/Annual Deductible

*** Ambulance Non-Emergency Out-of-Network benefit - HSA - Ded., then 40% and PPO - Ded., then 50%

Medical cont.

UnitedHealthcare offers a comprehensive prescription program with the medical plan. The table below shows the prescription benefits specific to each plan.

Pharmacy - HSA	
Retail Pharmacy (31 Day Supply)	
Tier 1	Ded., then $10 Copay
Tier 2	Ded., then $35 Copay
Tier 3	Ded., then $60 Copay
Tier 4	N/A

Pharmacy - PPO	
Retail Pharmacy (31 Day Supply)	
Tier 1	$15 Copay
Tier 2	$45 Copay
Tier 3	$85 Copay
Tier 4	$200 Copay

Employee Contributions (Bi-Weekly)	HSA Plan	PPO Plan
Employee Only	$44.50	$169.00
Employee & Spouse	$203.50	$374.00
Employee & Child(ren)	$145.25	$293.00
Employee & Family	$341.00	$540.00

Virtual Visits

See a doctor whenever, wherever.

When you're sick and need care quick, a Virtual Visit is a convenient way to start feeling better faster.

With a Virtual Visit, you can see and talk to a doctor via mobile device or computer — 24/7, no appointment needed. The doctor can give you a diagnosis and prescription, if needed. As part of your UnitedHealthcare plan, your cost is $50 or less.

To get started with a Virtual Visit, go to uhc.com/virtualvisits.

Get care in 20 minutes or less.

Use a Virtual Visit for these minor medical needs:

- Bladder infection/Urinary tract infection
- Bronchitis
- Cold/flu
- Fever
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomach ache

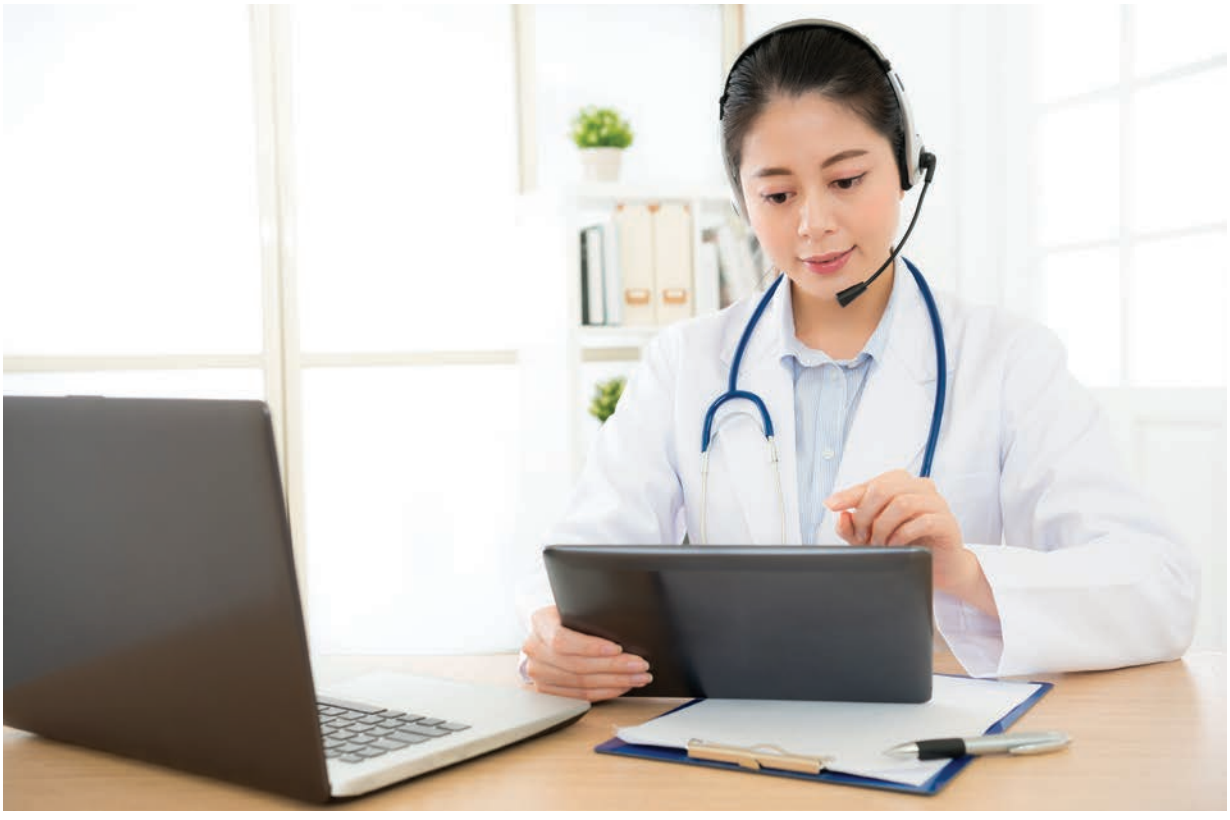
Prepare for your Virtual Visit.

Have these 3 items ready to register and complete your Virtual Visit:

- Health plan ID card
- Credit card
- Pharmacy location

Virtual Visits can save time and money.

An estimated 25 percent of ER visits could be treated with a Virtual Visit — which brings a potential $1,700 cost down to $50.



Health Savings Account (HSA)

The money in your HSA is always yours.

There is no "use it or lose it" rule. All amounts in your HSA are fully vested; any funds you don't spend roll over year after year. Your account belongs to you even if you:

- Change jobs
- Change medical coverage
- Become unemployed
- Move to another state
- Get married or divorced

Your BenefitWallet® Health Savings Account (HSA) allows you to save up to 35% in taxes on every dollar you contribute. When you spend your HSA funds on qualified expenses, you are never taxed. Use the funds to pay for a broad range of expenses for you, your spouse, and your tax dependents — even if they aren't covered by your health plan.

What Qualifies?

Doctors, Labs, and Hospitalization

- Doctor's office visits and procedures
- Drug addiction treatment
- Ambulance services
- Fertility treatment
- Health plan deductibles and copayments
- Hospital services
- Laboratory fees
- Surgery, excluding cosmetic surgery
- Vasectomy

Alternative Care and Special Services

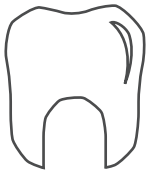
- Acupuncture
- Alcoholism treatment
- Chiropractor
- Drug addiction treatment
- Long-term care services (limited)
- Physical therapy
- Psychiatric care for mental health
- Special education for learning disabilities
- Speech therapy
- Weight loss programs (limited)

Prescriptions and Medical Devices

- Prescription drugs
- Over-the-counter medications prescribed by a doctor
- Artificial limbs
- Bandages
- Blood sugar test kits
- Breast pumps and lactation aids
- Crutches
- Hearing aids and batteries
- Insulin
- Stop-smoking programs and nicotine gum or patches
- Walkers
- Wheelchairs

Eye Doctor, Glasses, and Contacts

- Vision examinations
- Eye glasses
- Eye surgery
- Lasik/laser surgery
- Contact lenses
- Saline solution



Dentists and Orthodontics

- Dental treatments
- Dental x-rays
- Extractions
- Teeth cleanings
- Tooth removal
- Braces
- Dentures/ Artificial teeth

Need more information?

View the complete list of qualified expenses at irs.gov/pub/irs-pdf/p502.pdf

Save your receipts

Keep detailed receipts for all expenses paid from your HSA in case of an IRS audit.

We're Here to Help

For more information visit our website at mybenefitwallet.com or call us at 877.472.4200.

Vision

We are excited to offer a NEW robust Vision Plan that is **bundled** with the UnitedHealthcare Medical Plan. This includes a comprehensive eye exam, eyeglasses (frames and lens), or contact lens in lieu of eyeglasses.

	Vision Plan	
Benefit Coverage	**In-Network**	**Out-of-Network**
Copay		
Comprehensive Exams	$15	Up to $40
Lenses		
Single Vision Lenses	$30	Up to $40
Bifocal Lenses	$30	Up to $60
Trifocal Lenses	$30	Up to $80
Frames		
Private Practice Provider	$100	Up to $45
Retail Chain Provider	$100	Up to $45
Contact Lenses		
Necessary/Prescribed	$30	Up to $210
Elective	Up to $105	Up to $105
Other Services		
Laser Corrective Surgery	Members receive 15% off standard price or 5% off promotional price.	N/A
Frequency		
Comprehensive Exams	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
Contact Lenses	Once every 12 months	

Dental

BCBS of SC is the insurance carrier for our Dental Plan. Employees can choose to see an in or out-of-network Dentist. In-network benefits are based on a negotiated PPO fee schedule and treatment is reimbursed at a higher coinsurance percentage. Out-of-network benefits are based on local Usual, Customary and Reasonable charges.

To find an in-network Dentist with BCBS of SC visit their Dental Resource Center at www.southcarolinablues.com.

	BlueCross BlueShield of South Carolina Dental Plan	
	In-Network	**Out-of-Network**
Deductible per Plan Year	No Deductible	$50 Individual / $150 Family
Preventative Services (Examinations, X-rays, Prophylaxis, Sealants, Space maintainers, Fluoride treatments)	100%	100%; deductible waived
Basic Services (Endodontics, Oral surgery, Non-surgical periodontics, Surgical periodontics)	100%	80%
Major Services (Crowns, Bridges, Dentures, Inlays and onlays)	60%	50%
Plan Year Maximum (per Plan year)	$1,500	$1,500
Orthodontia (Dependent children up to age 19)	50%	50%; deducible waived
Orthodontia Lifetime Maximum	$1,500	$1,500

Employee Contributions (Bi-Weekly)	
Employee Only	$2.50
Employee + Spouse	$8.50
Employee + Child(ren)	$10.00
Family	$17.00

6 Things a Dental Cleaning Can Do for You

Group Life & Accidental Death & Dismemberment Insurance

SEM provides Company Paid Basic Life Insurance to all eligible employees through UNUM. Upon meeting eligibility requirements, you are automatically enrolled in Basic Life at no cost. Life insurance can protect your survivors from financial difficulty in the event of your death. AD&D insurance can provide assistance if you suffer accidental dismemberment or death resulting from an accident. Your basic life insurance amount is $20,000 with matching AD&D coverage. Dependents are also covered by this policy at no cost to you; there is a $10,000 benefit for your spouse and a $5,000 benefit for children to age 19 (age 26 if full-time student).

Employees who want to supplement their group life insurance benefits may purchase additional coverage. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through post-tax payroll deductions. You must purchase Voluntary Life Insurance on yourself in order to purchase it on your spouse and/or child. You have the opportunity to purchase Voluntary Life Insurance in increments of $10,000 up to $500,000 not to exceed a maximum of five (5) times your salary. For your spouse, you can purchase 100% of your Voluntary Life election up to $500,000. You may elect up to $10,000 for your dependent children. If you enroll when first eligible, you may elect up to the Guarantee Issued (GI) amount of $100,000 on yourself, $50,000 for your spouse and $10,000 on your child(ren) without proof of good health.

Contact Human Resources if you have questions regarding your life insurance coverage.

Employee age as of new plan year May 1, 2018	Monthly Rate per $10,000 Life & AD&D Insurance
less than age 25	$0.88
25-29	$0.88
30-34	$0.98
35-39	$1.18
40-44	$1.58
45-49	$2.58
50-54	$3.98
55-59	$6.08
60-64	$9.28
65-69	$16.48
70-74	$29.38
75 and over	$48.28

Spouse age as of new plan year May 1, 2018	Monthly Rate per $5,000 Life & AD&D Insurance
less than age 25	$0.44
25-29	$0.44
30-34	$0.49
35-39	$0.59
40-44	$0.79
45-49	$1.29
50-54	$1.99
55-59	$3.04
60-64	$4.64
65-69	$8.24
70-74	$14.69
75 and over	$24.14

Child Rate	Monthly Rate per $2,000 Life & AD&D
to age 19 (26 if full-time student)	$0.08

Disability

Short-Term Disability (STD)

Short-Term Disability (STD) insurance is an employer paid benefit through UNUM that provides partial income protection if you are unable to work due to an illness or injury. Your benefit covers 60% of your weekly salary up to $1,150 for a period up to 12 weeks. Benefits begin on the eighth day of the approved disability due to illness or injury.

Long-Term Disability (LTD)

Long-Term Disability (LTD) is an employer paid benefit through UNUM that provides partial income protection if a serious illness or injury causes you to be out on a medical leave of absence from work for more than ninety (90) days. The benefit provides you with 60% of your monthly earnings during your approved disability period up to a maximum of $10,000 per month.

Disability benefits must be approved by a physician and UNUM, the disability provider. Please contact Human Resources if you have questions regarding disability benefits.

Voluntary Accident Policy

This voluntary benefit is through Allstate and is separate from our UnitedHealthcare medical plan. This benefit pays you a set dollar amount for various services related to off the job accidents. It also has an added feature that will pay you or your covered dependents for seeing a doctor, dentist, eye doctor, chiropractor, etc. For visits not related to an accident. This benefit will pay you and your covered dependents $100 per visit to a maximum reimbursement of $200 for an individual and a maximum reimbursement for an employee with dependents of $400. This reimbursement feature is on a calendar year.

Base Policy Benefits	
Initial Hospital Confinement (pays once/year)	$2,000
Daily Hospital Confinement (pays daily)	$400
Intensive Care (pays daily)	$800
Additional Riders Added to Base	
Accident Treatment and Urgent Care Rider	
Ground Ambulance	$400
Air Ambulance	$1,200
Accident Physician's Treatment	$200
X-ray	$400
Urgent Care	$200
Dislocation or Fraction Rider	$8,000
Emergency Room Services Rider	$400
Additional Riders	
Outpatient Physician's Benefit Rider	$100
Accidental Dealth, Dismemberment, and Functional Loss Rider	$80,000
Common Carrier Accidental Death (fare-paying passenger)	$200,000

Voluntary Accident Policy cont.

Injury Benefit Schedule	
Complete Dislocation	
Hip joint	$8,000
Knee or ankle joint, bone or bones of the foot	$3,200
Wrist joint	$2,800
Elbow joint	$2,400
Shoulder joint	$1,600
Bone or bones of the hand, collarbone	$1,200
Two or more fingers or toes	$560
One finger or toe	$240
Complete, Simple or Closed Fracture	
Hip, thigh (femur), pelvis	$8,000
Skull	$7,600
Arm, between shoulder and elbow (shaft), shoulder blade (scapula), leg (tibia or fibula)	$4,400
Ankle, knee cap (patella), forearm (radius or ulna), collarbone (clavicle)	$3,200
Foot, hand or wrist	$2,800
Lower jaw	$1,600
Two or more ribs, fingers or toes, bones of face or nose	$1,200
One rib, finger or toe, coccyx	$560
Loss	
Life, hearing, speech, or both eyes, hands, arms, feet, or legs, or one hand or arm and one foot or leg	$80,000
One eye, hand, arm, foot, or leg	$40,000
One or more entire toes or fingers	$8,000

Employee Contributions (Bi-Weekly)	
Employee Only	$7.02
Employee & Spouse	$16.04
Employee & Child(ren)	$19.64
Employee & Family	$25.74

Paid Time Off (PTO)

All full-time employees are eligible for PTO when hired and will accrue at a rate of 2.25 hours each pay period. PTO cannot be taken until the employee has successfully completed their 90-day orientation period. PTO will be managed on a calendar year basis. Employees hired before July 1st will be eligible to receive their full PTO Bank in January of the following year as defined below:

Eligibility		
Years of Service	**PTO Allotment**	**Max Carryover**
0 – 4	100 hours	40 hours
5 – 14	140 hours	60 hours
15+	180 hours	80 hours

When an employee becomes eligible for an additional 40 hours of PTO due to their service anniversary, the 40 hours will be allocated ON the pay period in which your anniversary date falls.

PTO may be used in 15 minute increments and all employees are encouraged to take one full week per year. PTO may be carried over from one year to the next with the maximum carryover allotment shown above. Any unused PTO hours will be paid out upon termination of employment.

Sick time is managed separately from your PTO Bank. Full-time employees will begin accruing sick leave when hired at a rate equivalent to forty (40) hours per year (1.54 hours per pay period) and may begin using sick leave after completing the 90-day orientation period. These days can be carried over from year-to-year to a maximum of 320 hours. Unused sick days are not paid out at termination of employment.

SEM also provides time off for FMLA, Military Leave, Jury Duty, Bereavement Leave and Birth Leave.

Please see your Employee Handbook for further details on paid time off policies.

Holidays

SEM recognizes certain days of religious and historic importance as holidays, and pays regular, full-time, active employees ten hours straight time for each of the nine (9) holidays listed below:

- New Years Day
- Easter Monday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Eve
- Christmas Day
- Floating Day as indicated each year by SEM

The exact observance date will be communicated at the beginning of each year.

Retirement Plans

SEM believes its employees are our greatest asset and are truly an investment. We offer two (2) retirement plans that exemplify this philosophy and reward employees for long-term service: a 401(k) Plan and an Employee Stock Ownership Plan.

There is no waiting period to participate in our 401(k) Plan. Full-time employees are eligible to participate on their first day of employment. The company offers a traditional pre-tax 401(k) and a post-tax Roth 401(k). Currently the Company's match is 50% of the first 6% of wages the employee contributes, for a maximum of 3% of your compensation. The Company's match is discretionary and is subject to change.

The Employee Stock Ownership Plan (ESOP) is a Company funded plan and all full-time employees having worked 1,000 hours in the previous calendar year are eligible to participate the following year. Contributions are made annually by the company (not the employee). The contribution percentage is determined by the Board of Directors each year and has historically been between 10% and 12% of the employee's wages.

SEM Stock Purchase Plan

SEM believes strongly in employee ownership and therefore affords each employee the opportunity to own SEM stock. Stock is offered for purchase once a year and all full-time employees with at least 90 days of service at the end of the calendar year are eligible to participate the following year when stock is offered. The minimum share value that may be financed is $3,000 and the maximum per year and lifetime maximum is shown below.

SEM Stock Purchase Plan		
Hire Date	**Annual**	**Lifetime**
after 1-Oct-15	$35k	$70k
after 1-Oct-14	$35k	$60k
before 1-Oct-14	$25k	$50k

A 10% down payment is required when financing stock. An eligible employee may either make the 10% down payment in cash, or may finance the down payment or a portion of it, through payroll deductions from March through December. The balance shall be paid as prescribed in the Promissory Note. Interest rate on note set annually at .5% below prime rate as of January 1.

The minimum shares that may be purchased for cash are four (4) and the maximum is $35,000 per year.

The Board may change, modify, make exceptions to or revoke any or all portions of this program at any time.

The Board generally declares dividends at the end of March, May, August, November, and December. The March, May and August dividends are payable on or around the fifteenth of the following month. The November dividend is payable on January 15th or earlier. The December dividend is payable at the annual stockholders' meeting that is generally held in February or March.

Wellness Initiatives

As healthcare costs continue to rise, SEM strives to offer competitive health benefits to take care of you and your family. A successful wellness program is a win-win – it means our employees are improving their lives, and we are one step closer to managing rising health insurance costs.

Whether your goal is to have more energy, lose weight, manage stress, or improve your diet, participating in SEM's various wellness activities throughout the year can help. Wellness benefits include an in-house exercise facility, annual biometric screenings, on-site flu shots, biggest loser contest, 5k races and our annual walk at work lunch day.

We strongly believe our employees and company will benefit from a healthy workforce and overall wellness and well-being. We are always looking for new wellness initiatives/ideas and if you'd like to get involved, please see Human Resources to join the Wellness Committee.

Other SEM Benefits

- Employee Assistance Program (EAP)
- Flexible Schedule / Four (4) Day Work Week
- Company Paid Breaks
- Employee of the Quarter/Year
- Peer-to-Peer Recognition Program
- Recognition of Life Events
- Company Exercise Room

Important Contacts

Coverage	Carrier	Phone	Website
Medical	UnitedHealthcare	800-357-0978	www.myuhc.com
Vision	UnitedHealthcare	800-638-3120	www.myuhcvision.com
Dental	BCBS of SC	800-222-7156	www.southcarolinablues.com
Health Savings Account (HSA)	BenefitWallet	877-472-4200	www.mybenefitwallet.com
Short & Long Term Disability, Basic & Voluntary Life	UNUM	866-679-3054	www.UNUM.com
Voluntary Accident	Allstate	800-521-3535	www.allstateatwork.com/mybenefits
401(k)	Fidelity	800-294-4015	www.netbenefits.com

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.welcometouhc.com or by calling 1-866-673-6293. 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.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $2,000 Individual / $4,000 Family non-Network: $10,000 Individual / $20,000 Family Per policy year.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at 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?	Network: $4,000 Individual / $8,000 Family non-Network: $12,500 Individual / $25,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.welcometouhc.com or call 1-866-673-6293 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)	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	10% coinsurance	40% coinsurance	Virtual visits (Telehealth) - 10% coinsurance by a Designated Virtual Network Provider. No virtual coverage for non-Network.
	Specialist visit	10% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	No Charge	Not Covered	No coverage non-Network. 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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	Preauthorization required for non-Network for certain services or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	Preauthorization required for non-Network or benefit reduces to 50% of allowed.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouhc.com.	Tier 1 - Your Lowest-Cost Option	Retail: $10 copay Mail-Order: $25 copay	Retail: $10 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. If you use a non-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement prior to dispensing or may not be covered. 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. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: $35 copay Mail-Order: $87.50 copay	Retail: $35 copay	
	Tier 3 - Your Midrange-Cost Option	Retail: $60 copay Mail-Order: $150 copay	Retail: $60 copay	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Preauthorization required for certain services for non-Network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Preauthorization required for non-Network or benefit reduces to 50% of allowed.

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)	
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	40% coinsurance	Network partial hospitalization /intensive outpatient treatment: 10% coinsurance Preauthorization required for certain services for non-Network or benefit reduces to 50% of allowed.
	Inpatient services	10% coinsurance	40% coinsurance	Preauthorization required for non-Network or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	40% 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	10% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	Inpatient preauthorization apply for non-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	10% coinsurance	40% coinsurance	Limited to 60 visits per policy year. Preauthorization required for non-Network or benefit reduces to 50% of allowed.
	Rehabilitation services	10% coinsurance	40% coinsurance	Limits per policy year: Physical, Speech, Occupational, Pulmonary: 20 visits; Cardiac: 36 visits. Preauthorization required for certain services for non-Network or benefit reduces to 50% of allowed.
	Habilitation services	10% coinsurance	40% coinsurance	Services provided under and limits are combined with Rehabilitation services above. Preauthorization required for certain services for non-Network or benefit reduces to 50% of allowed.
	Skilled nursing care	10% coinsurance	40% coinsurance	Skilled Nursing is limited to 60 days per policy year (combined with Inpatient Rehabilitation). Preauthorization required for non-Network or benefit reduces to 50% of allowed.

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)	
	Durable medical equipment	10% coinsurance	40% coinsurance	Covers 1 per type of DME (including repair/replace) every 3 years. Preauthorization required for non-Network DME over $1,000 or no coverage.
	Hospice services	10% coinsurance	40% coinsurance	Preauthorization required for non-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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine eye care (Adult/Child)
- Routine Foot Care
- 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 policy year
- Hearing Aids-$2,500/ policy year

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, or 1-877-267-2323 x61565 or www.cciio.cms.gov for the U.S. Department of Health and Human Services. You may also contact us at 1-866-673-6293. 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: 1-866-673-6293 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the South Carolina Department of Insurance at 1-800-768-3467 or www.doi.sc.gov.

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 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 1-866-673-6293 .
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-673-6293 .
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-673-6293 .
Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-866-673-6293 .

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	$ 2,000
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	$12,800
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$30
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,990

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

The plan's overall deductible	$ 2,000
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$2,000
Copayments	$800
Coinsurance	$40
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$2,870

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

The plan's overall deductible	$ 2,000
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

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

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.welcometouhc.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.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $1,500 Individual / $3,000 Family non-Network: $3,000 Individual / $6,000 Family Per policy year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at 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?	Network: $6,600 Individual / $13,200 Family non-Network: $15,000 Individual / $30,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.welcometouhc.com or call 1-800-782-3740 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)	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	$25 copay per visit, deductible does not apply	50% coinsurance	Virtual visits (Telehealth) - $10 copay per visit by a Designated Virtual Network Provider, deductible does not apply. No virtual coverage for non-Network. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Specialist visit	$50 copay per visit, deductible does not apply	50% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/immunization	No Charge	Not Covered	No coverage non-Network. 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.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	Preauthorization required for non-Network for certain services or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization required for non-Network or benefit reduces to 50% of allowed.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouhc.com.	Tier 1 - Your Lowest-Cost Option	Deductible does not apply. Retail: $15 copay Mail-Order: $45 copay	Deductible does not apply. Retail: $15 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. If you use a non-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement prior to dispensing or may not be covered. 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. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Deductible does not apply. Retail: $45 copay Mail-Order: $135 copay	Deductible does not apply. Retail: $45 copay	
	Tier 3 - Your Midrange-Cost Option	Deductible does not apply. Retail: $85 copay Mail-Order: $255 copay	Deductible does not apply. Retail: $85 copay	
	Tier 4 - Additional High-Cost Options	Deductible does not apply. Retail: $200 copay Mail-Order: $600 copay	Deductible does not apply. Retail: $200 copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization required for certain services for non-Network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$350 copay per visit, deductible does not apply	$350 copay per visit, deductible does not apply	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None

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)	
	Urgent care	$50 copay per visit, deductible does not apply	50% coinsurance	If you receive services in addition to urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization required for non-Network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay per visit, deductible does not apply	50% coinsurance	Network partial hospitalization /intensive outpatient treatment: 20% coinsurance Preauthorization required for certain services for non-Network or benefit reduces to 50% of allowed.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization required for non-Network or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	50% 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	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Inpatient preauthorization apply for non-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	50% coinsurance	Limited to 60 visits per policy year. Preauthorization required for non-Network or benefit reduces to 50% of allowed.
	Rehabilitation services	$25 copay per outpatient visit, deductible does not apply	50% coinsurance	Limits per policy year: Physical, Speech, Occupational, Pulmonary: 20 visits; Cardiac: 36 visits. Preauthorization required for certain services for non-Network or benefit reduces to 50% of allowed.
	Habilitation services	$25 copay per outpatient visit, deductible does not apply	50% coinsurance	Services provided under and limits are combined with Rehabilitation services above. Preauthorization required for certain services for non-Network or benefit reduces to 50% of allowed.

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	Skilled Nursing is limited to 60 days per policy year (combined with Inpatient Rehabilitation). Preauthorization required for non-Network or benefit reduces to 50% of allowed.
	Durable medical equipment	20% coinsurance	50% coinsurance	Covers 1 per type of DME (including repair/replace) every 3 years. Preauthorization required for non-Network DME over $1,000 or no coverage.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization required for non-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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine eye care (Adult/Child)
- Routine Foot Care
- 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 policy year
- Hearing Aids-$2,500/ policy year

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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: 1-800-782-3740 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the South Carolina Department of Insurance at 1-800-768-3467 or www.doi.sc.gov.

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 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 .
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740 .
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-782-3740 .
Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 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)

- **The plan's overall deductible** $ 1,500
- **Specialist copayment** $50
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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

Total Example Cost	$12,800
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$30
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,290

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

- **The plan's overall deductible** $ 1,500
- **Specialist copayment** $50
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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

Total Example Cost	$7,400
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$1,630

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

- **The plan's overall deductible** $ 1,500
- **Specialist copayment** $50
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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

Total Example Cost	$1,900
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$700
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,200

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

Notice of Non-Discrimination

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.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث العربية **(Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ **(Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្តាង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការគ្របដណ្តប់ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

Notes

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