This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.mytree.hrintouch.com** or by calling **1-855-245-7994.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $3,500 Individual / $7,000 Family Non-Network: $6,000 Individual / $12,000 Family Per calendar year. Does not apply to copays, and services listed below as "No Charge".	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No, there are no other **deductibles**.	You don't have to meet **deductibles** for specific service, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Medical- Network: $6,250 Individual / $12,500 Family Non-Network: $12,500 Individual / $25,000 Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premiums**, balanced-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes, this plan uses **network providers**. If you use a **non-network provider** your cost may be more. For a list of **network providers**, see www.myuhc.com or call 1-888-355-2509.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on Page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-355-2509 or visit us at www.mytree.hrintouch.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number above to request a copy.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 Copay/visit	60% Coinsurance After Deductible	Virtual visit - Network $50 copay per visit by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Christian Science Practitioners are not covered.
	Specialist visit	$85 Copay/visit	60% Coinsurance After Deductible	Christian Science Practitioners are not covered.
	Other practitioner office visit	$85 Copay/visit	60% Coinsurance After Deductible	Cost Share applies for only Manipulative (Chiropractic) Care. 15 visits per calendar year. $85 Specialist copay is always taken for Network office.
	Preventive care/screening/immunization	No Charge	60% Coinsurance After Deductible	Includes preventive health services specified in the health care reform law. Includes preventive health services specified in the Heath Care Reform law.
If you have a test	Diagnostic test (x-ray, blood work)	40% Coinsurance After Deductible	60% Coinsurance After Deductible	Advance Notification required for Non-Network Sleep Studies or benefit will not be covered.
	Imaging (CT/PET scans, MRIs)	40% Coinsurance After Deductible	60% Coinsurance After Deductible	CT PET, Nuclear Medicine and MRI in any location are paid at applicable plan level deductible/coinsurance.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**.	Tier 1 - Your Lowest-Cost Option	Retail: 40% Coinsurance After Deductible Mail Order: 40% Coinsurance After Deductible	Retail: N/A Mail Order: N/A	Generic Preventive: 20% before and after deductible Contact Express Scripts 1-877-860-7120 or express-scripts.com
	Tier 2 - Your Midrange-Cost Option	Retail: 40% Coinsurance After Deductible Mail Order: 40% Coinsurance After Deductible	Retail: N/A Mail Order: N/A	Generic Preventive: 20% before and after deductible Contact Express Scripts 1-877-860-7120 or express-scripts.com
	Tier 3 - Your Highest-Cost Option	Retail: 40% Coinsurance After Deductible Mail Order: 40% Coinsurance After Deductible	Retail: N/A Mail Order: N/A	Generic Preventive: 20% before and after deductible Contact Express Scripts 1-877-860-7120 or express-scripts.com
	Tier 4 - Additional High-Cost Option	Retail: Not Covered Mail Order: Not Covered	Retail: N/A Mail Order: N/A	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% Coinsurance After Deductible	60% Coinsurance After Deductible	Office surgery 100% no deductible after copay.
	Physician/surgeon fees	40% Coinsurance After Deductible	60% Coinsurance After Deductible	Christian Science Practitioners are not covered.
If you need immediate medical attention	Emergency room services	40% Coinsurance After Deductible	40% Coinsurance After Deductible	Network and Non-Network True emergency paid at Network level. ER use for non-emergency paid at Non-Network deductible/coinsurance.
	Emergency medical transportation	40% Coinsurance After Deductible	40% Coinsurance After Deductible	Land/Air Ambulance services are covered when medically necessary.
	Urgent care	$85 Copay/visit	60% Coinsurance After Deductible	$85 copay for Network Office and Facility locations.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% Coinsurance After Deductible	60% Coinsurance After Deductible	None
	Physician/surgeon fee	40% Coinsurance After Deductible	60% Coinsurance After Deductible	Christian Science Practitioners are not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 Copay/visit	60% Coinsurance After Deductible	Christian Science Practitioners are not covered. EAP is 3 face to face sessions unlimited telephonic.
	Mental/Behavioral health inpatient services	40% Coinsurance After Deductible	60% Coinsurance After Deductible	Christian Science Practitioners are not covered.
	Substance use disorder outpatient services	$50 Copay/visit	60% Coinsurance After Deductible	Christian Science Practitioners are not covered. EAP is 3 face to face sessions unlimited telephonic.
	Substance use disorder inpatient services	40% Coinsurance After Deductible	60% Coinsurance After Deductible	Christian Science Practitioners are not covered.
If you are pregnant	Prenatal and postnatal care	40% Coinsurance After Deductible	60% Coinsurance After Deductible	Routine Prenatal care covered at no charge. Your cost in this category includes physician delivery charges. Dependent daughter maternity covered but newborn nursery is not.
	Delivery and all inpatient services	40% Coinsurance After Deductible	60% Coinsurance After Deductible	Your cost for inpatient services only. For physician delivery charges, see pre-postnatal care. Stays exceeding delivery timeframes advance notification is required. Dependent daughter maternity covered but newborn nursery is not.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	40% Coinsurance After Deductible	60% Coinsurance After Deductible	Unlimited visits: 16-hour-day maximum. Does not apply to Private Duty Nursing benefit.
	Rehabilitation services	$50 Copay/visit	60% Coinsurance After Deductible	Occupational and Physical therapies combined for 30 visits per calendar year. Speech therapy has 30 visits per calendar year. Network and Non-Network visits combined toward calendar year maximum.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	40% Coinsurance After Deductible	60% Coinsurance After Deductible	Limited to 100 days maximum per confinement. Network and Non-Network combined for maximum days per confinement. Custodial Care not covered.
	Durable medical equipment	40% Coinsurance After Deductible	60% Coinsurance After Deductible	Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item) requires advance notification. Limited to one wig per calendar year (subject to Medical Necessity).
	Hospice service	40% Coinsurance After Deductible	60% Coinsurance After Deductible	Attending Physician must certify the Member is not expected to live more than six months. The Physician must design and recommend a Hospice Care Program.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Spinal Manipulation

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care limitations may apply
- Private-duty nursing limitations may apply
- Routine foot care limitations may apply

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-0048. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov .

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us at 1-800-876-8697 or visit www.mytree.hrintouch.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-888-355-2509.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-355-2509.
- Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-355-2509.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-355-2509.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $2,380
- **Patient pays:** $5,160

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,500
Copays	$0
Coinsurance	$1,510
Limits or exclusions	$150
Total	$5,160

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,100
- **Patient pays:** $4,300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3,500
Copays	$50
Coinsurance	$670
Limits or exclusions	$80
Total	$4,300

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example Show

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.mytree.hrintouch.com** or by calling **1-855-245-7994.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $2,500 Individual / $5,000 Family Non-Network: $5,000 Individual / $10,000 Family Per calendar year. Does not apply to copays, pharmacy drugs, and services listed below as "No Charge".	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No, there are no other **deductibles**.	You don't have to meet **deductibles** for specific service, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Medical- Network: $6,250 Individual / $12,500 Family Non-Network: $12,500 Individual / $25,000 Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premiums**, balanced-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes, this plan uses **network providers**. If you use a **non-network provider** your cost may be more. For a list of **network providers**, see www.myuhc.com or call 1-888-355-2509.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on Page 7. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-355-2509 or visit us at www.mytree.hrintouch.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number above to request a copy.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 Copay/visit	40% Coinsurance After Deductible	Virtual visit - Network $35 copay per visit by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Christian Science Practitioners are not covered.
	Specialist visit	$50 Copay/visit	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.
	Other practitioner office visit	$50 Copay/visit	40% Coinsurance After Deductible	Cost Share applies for only Manipulative (Chiropractic) Care. 15 visits per calendar year. $50 Specialist copay is always taken for Network office.
	Preventive care/screening/immunization	No Charge	40% Coinsurance After Deductible	Includes preventive health services specified in the health care reform law.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Network lab and x-ray done in office are covered at 100% no deductible or copay applies. Network Lab work done in an independent lab or outpatient hospital will pay at $35 PCP copay/100% (Specialist copay will not apply, only PCP). X-rays will continue to pay at plan level - because office is 100% (no copay), all other locations are deductible/coinsurance.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	CT PET, Nuclear Medicine and MRI in any location are paid at applicable plan level deductible/coinsurance.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**.	Tier 1 - Your Lowest-Cost Option	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Retail: N/A Mail Order: N/A	Retail $10 min to $30 max; Mail order $20 min to $60 max. Contact Express Scripts 1-877-860-7120 or express-scripts.com
	Tier 2 - Your Midrange-Cost Option	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Retail: N/A Mail Order: N/A	Retail $25 min to $60 max; Mail order $50 min to $120 max. Contact Express Scripts 1-877-860-7120 or express-scripts.com
	Tier 3 - Your Highest-Cost Option	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Retail: N/A Mail Order: N/A	Retail $40 min to $100 max; Mail order $80 min to $200 max. Contact Express Scripts 1-877-860-7120 or express-scripts.com
	Tier 4 - Additional High-Cost Option	Retail: Not Covered Mail Order: Not Covered	Retail: N/A Mail Order: N/A	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Physician/surgeon fees	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Network and Non-Network True emergency paid at Network level. ER use for non-emergency paid at Non-Network deductible/coinsurance.
	Emergency medical transportation	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Land/Air Ambulance services are covered when medically necessary.
	Urgent care	$50 Copay/visit	40% Coinsurance After Deductible	$50 copay for Network Office and Facility locations.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Physician/surgeon fee	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 Copay/visit	40% Coinsurance After Deductible	Partial Hospitalization/Intensive outpatient: 20% coinsurance after Deductible. Christian Science Practitioners are not covered. EAP is 3 face to face sessions unlimited telephonic.
	Mental/Behavioral health inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.
	Substance use disorder outpatient services	$35 Copay/visit	40% Coinsurance After Deductible	Partial Hospitalization/Intensive outpatient: 20% coinsurance after Deductible. Christian Science Practitioners are not covered. EAP is 3 face to face sessions unlimited telephonic.
	Substance use disorder inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.
If you are pregnant	Prenatal and postnatal care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Routine Prenatal care covered at no charge. Your cost in this category includes physician delivery charges. Dependent daughter maternity covered but newborn nursery is not.
	Delivery and all inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Your cost for inpatient services only. For physician delivery charges, see pre-postnatal care. Stays exceeding delivery timeframes advance notification is required. Dependent daughter maternity covered but newborn nursery is not.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Unlimited visits: 16-hour-day maximum. Does not apply to Private Duty Nursing benefit.
	Rehabilitation services	$35 Copay/visit	40% Coinsurance After Deductible	Occupational and Physical therapies combined for 30 visits per calendar year. Speech therapy has 30 visits per calendar year. Network and Non-Network visits combined toward calendar year maximum.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Limited to 100 days maximum per confinement. Network and Non-Network combined for maximum days per confinement. Custodial Care not covered.
	Durable medical equipment	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item) requires advance notification. Limited to one wig per calendar year (subject to Medical Necessity).
	Hospice service	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Attending Physician must certify the Member is not expected to live more than six months. The Physician must design and recommend a Hospice Care Program.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Spinal Manipulation

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care limitations may apply
- Private-duty nursing limitations may apply
- Routine foot care limitations may apply

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-0048. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov .

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us at 1-800-876-8697 or visit www.mytree.hrintouch.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-355-2509.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,930
- **Patient pays:** $3,610

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,500
Copays	$0
Coinsurance	$960
Limits or exclusions	$150
Total	$3,610

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,350
- **Patient pays:** $2,050

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,150
Copays	$0
Coinsurance	$820
Limits or exclusions	$80
Total	$2,050

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example Show

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.mytree.hrintouch.com** or by calling **1-855-245-7994.**

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 calendar year. Does not apply to copays, pharmacy drugs, and services listed below as "No Charge".	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No, there are no other **deductibles**.	You don't have to meet **deductibles** for specific service, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Medical- Network: $5,000 Individual / $10,000 Family Non-Network: $10,000 Individual / $20,000 Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premiums**, balanced-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes, this plan uses **network providers**. If you use a **non-network provider** your cost may be more. For a list of **network providers**, see www.myuhc.com or call 1-888-355-2509.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on Page 8. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-355-2509 or visit us at www.mytree.hrintouch.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number above to request a copy.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 Copay/visit	40% Coinsurance After Deductible	Virtual visit - Network $35 copay per visit by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Christian Science Practitioners are not covered.
	Specialist visit	$50 Copay/visit	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.
	Other practitioner office visit	$50 Copay/visit	40% Coinsurance After Deductible	Cost Share applies for only Manipulative (Chiropractic) Care. 15 visits per calendar year. $50 Specialist copay is always taken for Network office.
	Preventive care/screening/immunization	No Charge	40% Coinsurance After Deductible	Includes preventive health services specified in the health care reform law.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Network lab and x-ray done in office are covered at 100% no deductible or copay applies. Network Lab work done in an independent lab or outpatient hospital will pay at $35 PCP copay/100% (Specialist copay will not apply, only PCP). X-rays will continue to pay at plan level - because office is 100% (no copay), all other locations are deductible/coinsurance.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	CT PET, Nuclear Medicine and MRI in any location are paid at applicable plan level deductible/coinsurance.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**.	Tier 1 - Your Lowest-Cost Option	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Retail: N/A Mail Order: N/A	Retail $10 min to $30 max; Mail order $20 min to $60 max. Contact Express Scripts
	Tier 2 - Your Midrange-Cost Option	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Retail: N/A Mail Order: N/A	Retail $25 min to $60 max; Mail order $50 min to $120 max. Contact Express Scripts 1-877-860-7120 or express-scripts.com
	Tier 3 - Your Highest-Cost Option	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Retail: N/A Mail Order: N/A	Retail $40 min to $100 max; Mail order $80 min to $200 max. Contact Express Scripts 1-877-860-7120 or express-scripts.com
	Tier 4 - Additional High-Cost Option	Retail: Not Covered Mail Order: Not Covered	Retail: N/A Mail Order: N/A	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Physician/surgeon fees	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Network and Non-Network True emergency paid at Network level. ER use for non-emergency paid at Non-Network deductible/coinsurance.
	Emergency medical transportation	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Land/Air Ambulance services are covered when medically necessary.
	Urgent care	$50 Copay/visit	40% Coinsurance After Deductible	$50 copay for Network Office and Facility locations.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Physician/surgeon fee	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 Copay/visit	40% Coinsurance After Deductible	Partial Hospitalization/Intensive outpatient: 20% coinsurance after Deductible. Christian Science Practitioners are not covered. EAP is 3 face to face sessions unlimited telephonic.
	Mental/Behavioral health inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.
	Substance use disorder outpatient services	$35 Copay/visit	40% Coinsurance After Deductible	Partial Hospitalization/Intensive outpatient: 20% coinsurance after Deductible. Christian Science Practitioners are not covered. EAP is 3 face to face sessions unlimited telephonic.
	Substance use disorder inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.
If you are pregnant	Prenatal and postnatal care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Routine Prenatal care covered at no charge. Your cost in this category includes physician delivery charges. Dependent daughter maternity covered but newborn nursery is not.
	Delivery and all inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Your cost for inpatient services only. For physician delivery charges, see pre-postnatal care. Stays exceeding delivery timeframes advance notification is required. Dependent daughter maternity covered but newborn nursery is not.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Unlimited visits: 16-hour-day maximum. Does not apply to Private Duty Nursing benefit.
	Rehabilitation services	$35 Copay/visit	40% Coinsurance After Deductible	Occupational and Physical therapies combined for 30 visits per calendar year. Speech therapy has 30 visits per calendar year. Network and Non-Network visits combined toward calendar year maximum.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Limited to 100 days maximum per confinement. Network and Non-Network combined for maximum days per confinement. Custodial Care not covered.
	Durable medical equipment	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item) requires advance notification. Limited to one wig per calendar year (subject to Medical Necessity).
	Hospice service	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Attending Physician must certify the Member is not expected to live more than six months. The Physician must design and recommend a Hospice Care Program.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Spinal Manipulation

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care limitations may apply
- Private-duty nursing limitations may apply
- Routine foot care limitations may apply

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
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See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays: $4,730
- Patient pays: $2,810

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$1,160
Limits or exclusions	$150
Total	$2,810

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays: $3,350
- Patient pays: $2,050

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,150
Copays	$0
Coinsurance	$820
Limits or exclusions	$80
Total	$2,050

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example Show

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

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Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,000 Individual / $2,000 Family Non-Network: $2,000 Individual / $4,000 Family Per calendar year. Does not apply to copays, pharmacy drugs, and services listed below as "No Charge".	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No, there are no other **deductibles**.	You don't have to meet **deductibles** for specific service, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Medical- Network: $3,000 Individual / $6,000 Family Non-Network: $6,000 Individual / $12,000 Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premiums**, balanced-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes, this plan uses **network providers**. If you use a **non-network provider** your cost may be more. For a list of **network providers**, see www.myuhc.com or call 1-888-355-2509.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on Page 8. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-355-2509 or visit us at www.mytree.hrintouch.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number above to request a copy.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 Copay/visit	40% Coinsurance After Deductible	Virtual visit - Network $35 copay per visit by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Christian Science Practitioners are not covered.
	Specialist visit	$50 Copay/visit	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.
	Other practitioner office visit	$50 Copay/visit	40% Coinsurance After Deductible	Cost Share applies for only Manipulative (Chiropractic) Care. 15 visits per calendar year. $50 Specialist copay is always taken for Network office.
	Preventive care/screening/immunization	No Charge	40% Coinsurance After Deductible	Includes preventive health services specified in the health care reform law. Includes preventive health services specified in the Heath Care Reform law.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Network lab and x-ray done in office are covered at 100% no deductible or copay applies. Network Lab work done in an independent lab or outpatient hospital will pay at $35 PCP copay/100% (Specialist copay will not apply, only PCP). X-rays will continue to pay at plan level - because office is 100% (no copay), all other locations are deductible/coinsurance.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	CT PET, Nuclear Medicine and MRI in any location are paid at applicable plan level deductible/coinsurance.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**.	Tier 1 - Your Lowest-Cost Option	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Retail: N/A Mail Order: N/A	Retail $10 min to $30 max; Mail order $20 min to $60 max. Contact Express Scripts 1-877-860-7120 or express-scripts.com
	Tier 2 - Your Midrange-Cost Option	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Retail: N/A Mail Order: N/A	Retail $25 min to $60 max; Mail order $50 min to $120 max. Contact Express Scripts 1-877-860-7120 or express-scripts.com
	Tier 3 - Your Highest-Cost Option	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Retail: N/A Mail Order: N/A	Retail $40 min to $100 max; Mail order $80 min to $200 max. Contact Express Scripts 1-877-860-7120 or express-scripts.com 1-877-860-7120 or express-scripts.com
	Tier 4 - Additional High-Cost Option	Retail: Not Covered Mail Order: Not Covered	Retail: N/A Mail Order: N/A	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Physician/surgeon fees	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Network and Non-Network True emergency paid at Network level.
	Emergency medical transportation	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Network and Non-Network paid at Network level when Land/Air Ambulance services are covered when medically necessary.
	Urgent care	$50 Copay/visit	40% Coinsurance After Deductible	$50 copay for Network Office and Facility locations.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Physician/surgeon fee	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 Copay/visit	40% Coinsurance After Deductible	Christian Science Practitioners are not covered. EAP is 3 face to face sessions unlimited telephonic.
	Mental/Behavioral health inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.
	Substance use disorder outpatient services	$35 Copay/visit	40% Coinsurance After Deductible	Christian Science Practitioners are not covered. EAP is 3 face to face sessions unlimited telephonic.
	Substance use disorder inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.
If you are pregnant	Prenatal and postnatal care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Routine Prenatal care covered at no charge. Your cost in this category includes physician delivery charges. Dependent daughter maternity covered but newborn nursery is not.
	Delivery and all inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Your cost for inpatient services only. For physician delivery charges, see pre-postnatal care. Stays exceeding delivery timeframes advance notification is required. Dependent daughter maternity covered but newborn nursery is not.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Unlimited visits: 16-hour-day maximum. Does not apply to Private Duty Nursing benefit.
	Rehabilitation services	$35 Copay/visit	40% Coinsurance After Deductible	Occupational and Physical therapies combined for 30 visits per calendar year. Speech therapy has 30 visits per calendar year. Network and Non-Network visits combined toward calendar year maximum.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Limited to 100 days maximum per confinement. Network and Non-Network combined for maximum days per confinement. Custodial Care not covered.
	Durable medical equipment	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item) requires advance notification. Limited to one wig per calendar year (subject to Medical Necessity).
	Hospice service	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Attending Physician must certify the Member is not expected to live more than six months. The Physician must design and recommend a Hospice Care Program.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Spinal Manipulation

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care limitations may apply
- Private-duty nursing limitations may apply
- Routine foot care limitations may apply

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-0048. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov .

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us at 1-800-876-8697 or visit www.mytree.hrintouch.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-888-355-2509.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-355-2509.
- Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-355-2509.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-355-2509.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays: $5,130
- Patient pays: $2,410

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$1,260
Limits or exclusions	$150
Total	$2,410

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays: $3,430
- Patient pays: $1,970

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Copays	$70
Coinsurance	$820
Limits or exclusions	$80
Total	$1,970

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example Show

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.mytree.hrintouch.com** or by calling **1-855-245-7994.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $500 Individual / $1,000 Family Non-Network: $1,000 Individual / $2,000 Family Per calendar year. Does not apply to copays, pharmacy drugs, and services listed below as "No Charge".	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No, there are no other **deductibles**.	You don't have to meet **deductibles** for specific service, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Medical- Network: $1,500 Individual / $3,000 Family Non-Network: $3,000 Individual / $6,000 Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premiums**, balanced-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes, this plan uses **network providers**. If you use a **non-network provider** your cost may be more. For a list of **network providers**, see www.myuhc.com or call 1-888-355-2509.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on Page 7. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-355-2509 or visit us at www.mytree.hrintouch.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number above to request a copy.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 Copay/visit	40% Coinsurance After Deductible	Virtual visit - Network $35 copay per visit by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Christian Science Practitioners are not covered.
	Specialist visit	$50 Copay/visit	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.
	Other practitioner office visit	$50 Copay/visit	40% Coinsurance After Deductible	Cost Share applies for only Manipulative (Chiropractic) Care. 15 visits per calendar year. $50 Specialist copay is always taken for Network office.
	Preventive care/screening/immunization	No Charge	40% Coinsurance After Deductible	Includes preventive health services specified in the health care reform law.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Network lab and x-ray done in office are covered at 100% no deductible or copay applies. Network Lab work done in an independent lab or outpatient hospital will pay at $35 PCP copay/100% (Specialist copay will not apply, only PCP). X-rays will continue to pay at plan level - because office is 100% (no copay), all other locations are deductible/coinsurance.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	CT PET, Nuclear Medicine and MRI in any location are paid at applicable plan level deductible/coinsurance.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**.	Tier 1 - Your Lowest-Cost Option	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Retail: N/A Mail Order: N/A	Retail $10 min to $30 max; Mail order $20 min to $60 max. Contact Express Scripts 1-877-860-7120 or express-scripts.com
	Tier 2 - Your Midrange-Cost Option	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Retail: N/A Mail Order: N/A	Retail $25 min to $60 max; Mail order $50 min to $120 max. Contact Express Scripts 1-877-860-7120 or express-scripts.com
	Tier 3 - Your Highest-Cost Option	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Retail: N/A Mail Order: N/A	Retail $40 min to $100 max; Mail order $80 min to $200 max. Contact Express Scripts 1-877-860-7120 or express-scripts.com
	Tier 4 - Additional High-Cost Option	Retail: Not Covered Mail Order: Not Covered	Retail: N/A Mail Order: N/A	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Physician/surgeon fees	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Network and Non-Network True emergency paid at Network level. ER use for non-emergency paid at Non-Network deductible/coinsurance.
	Emergency medical transportation	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Land/Air Ambulance services are covered when medically necessary.
	Urgent care	$50 Copay/visit	40% Coinsurance After Deductible	$50 copay for Network Office and Facility locations.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Physician/surgeon fee	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 Copay/visit	40% Coinsurance After Deductible	Partial Hospitalization/Intensive outpatient: 20% coinsurance after Deductible. Christian Science Practitioners are not covered. EAP is 3 face to face sessions unlimited telephonic.
	Mental/Behavioral health inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.
	Substance use disorder outpatient services	$35 Copay/visit	40% Coinsurance After Deductible	Partial Hospitalization/Intensive outpatient: 20% coinsurance after Deductible. Christian Science Practitioners are not covered. EAP is 3 face to face sessions unlimited telephonic.
	Substance use disorder inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Christian Science Practitioners are not covered.
If you are pregnant	Prenatal and postnatal care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Routine Prenatal care covered at no charge. Your cost in this category includes physician delivery charges. Dependent daughter maternity covered but newborn nursery is not.
	Delivery and all inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Your cost for inpatient services only. For physician delivery charges, see pre-postnatal care. Stays exceeding delivery timeframes advance notification is required. Dependent daughter maternity covered but newborn nursery is not.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Unlimited visits: 16-hour-day maximum. Does not apply to Private Duty Nursing benefit.
	Rehabilitation services	$35 Copay/visit	40% Coinsurance After Deductible	Occupational and Physical therapies combined for 30 visits per calendar year. Speech therapy has 30 visits per calendar year. Network and Non-Network visits combined toward calendar year maximum.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Limited to 100 days maximum per confinement. Network and Non-Network combined for maximum days per confinement. Custodial Care not covered.
	Durable medical equipment	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item) requires advance notification. Limited to one wig per calendar year (subject to Medical Necessity).
	Hospice service	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Attending Physician must certify the Member is not expected to live more than six months. The Physician must design and recommend a Hospice Care Program.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
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To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

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If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays: $5,890
- Patient pays: $1,650

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance	$1,000
Limits or exclusions	$150
Total	$1,650

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays: $3,820
- Patient pays: $1,580

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$210
Coinsurance	$790
Limits or exclusions	$80
Total	$1,580

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example Show

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

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Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-888-355-2509 or visit us at www.mytree.hrintouch.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number above to request a copy.