



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.welcometouhc.com or by calling 1-800-782-3740.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: \$1,000 Indiv / \$2,000 Family Non-Network: \$3,000 Indiv / \$6,000 Family Per calendar year. Does not apply to prescription drugs, services listed below as "No Charge" and copays except as noted below.	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.	You don't have to meet deductibles for specific services, 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?	Yes, Network: \$4,000 Indiv / \$8,000 Family Non-Network: \$8,000 Indiv / \$16,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization 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?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers , see www.welcometouhc.com or call 1-800-782-3740.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-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 does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-782-3740 or visit us at www.welcometouhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 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	\$30 copay per visit	50% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	\$60 copay per visit	50% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	\$30 copay per visit	50% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Preventive care/screening/immunization	No Charge	50% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	20% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.

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.welcometouh-c.com .	Tier 1 - Your Lowest-Cost Option	Retail: \$15 copay Mail-Order: \$37.50 copay	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. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Authorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: \$40 copay Mail-Order: \$100 copay	Retail: \$40 copay	
	Tier 3 - Your Highest-Cost Option	Retail: \$75 copay Mail-Order: \$187.50 copay	Retail: \$75 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	20% co-ins, after ded	50% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	\$300 copay per visit	\$300 copay per visit	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	Network Deductible applies.
	Urgent care	\$100 copay per visit	50% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	20% co-ins, after ded	50% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$60 copay per visit	50% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.

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
	Mental/Behavioral health inpatient services	20% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	\$60 copay per visit	50% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	20% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
If you are pregnant	Prenatal and postnatal care	No Charge	50% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	20% co-ins, after ded	50% co-ins, after ded	Inpatient Authorization may apply.
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	50% co-ins, after ded	Limited to 60 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Rehabilitation services	\$30 copay per outpatient visit	50% co-ins, after ded	Limits per policy period: Physical, Speech, Occupational, Pulmonary 20 visits. Cardiac 36 visits. Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Habilitative services	\$30 copay per outpatient visit	50% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed. Services provided under Rehabilitation services above.
	Skilled nursing care	20% co-ins, after ded	50% co-ins, after ded	Limited to 60 days per policy period (combined with Inpatient Rehabilitation). Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Durable medical equipment	20% co-ins, after ded	50% co-ins, after ded	Covers 1 per type of DME (including repair/replace) every 3 years. Pre-Authorization required for non-network DME over \$1,000 or no coverage.
	Hospice service	20% co-ins, after ded	50% co-ins, after ded	Inpatient Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No coverage for Eye exam.
	Glasses	Not Covered	Not Covered	No coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

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
- Long-term care
- Weight loss programs
- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Private-duty nursing
- Dental care (Adult/Child)
- Routine eye care (Adult/Child)
- Glasses
- Routine foot care

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

- Chiropractic care
- Hearing aids
- Infertility treatment

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 1-866-747-1019. 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 the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the Illinois Department of Insurance at 1-866-445-5364 or www.insurance.illinois.gov. Additionally, a consumer assistance program can help you file your appeal. Contact Illinois Department of Insurance at 1-877-527-9431 in Springfield at 1-217-782-4515 or visit www.insurance.illinois.gov.

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:

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

如果需要中文的帮助, 请拨打这个号码 1-800-782-3740

Dinek'ehgo shika at' ohwol ninisingo, kwiiijigo holne' 1-800-782-3740

Para obtener asistencia en Español, llame al 1-800-782-3740

_____ *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 will also be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,220
- Patient pays \$2,320

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	\$20
Coinsurance	\$1,100
Limits or exclusions	\$200
Total	\$2,320

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,320
- Patient pays \$2,080

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	\$1,000
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$2,080

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

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?

x 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?

x 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.

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