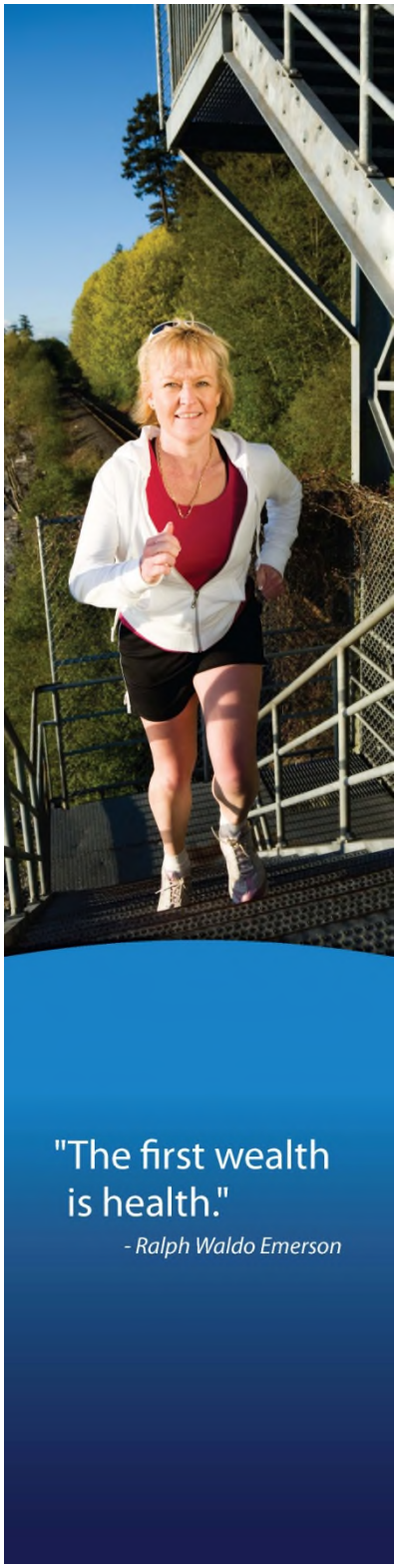
ADROIT

Health and Benefits Election Packet

2021-2022



Dear Valued Employees:

This Health Benefits Guide summarizes the health insurance options available for 2021-2022. Please review the guide carefully so you can choose plans that best fit the needs of you and your family.

Open Enrollment
Open enrollment is your annual opportunity to enroll in health benefits. During this time, you can also transfer

If your current plans are still offered and if you and your dependents continue to meet eligibility requirements, you will **automatically** be enrolled to continue your current elections in the upcoming benefit year. You need to take action **only** if you are making changes to your benefits.

If you have questions or need more information, please contact Rajay Goyal at rajay@adroitgroup.com or at 617-371-2930.

Sincerely,

Adroit Software Inc.

Health Benefits Eligibility Requirements and Deadlines

Who is eligible for health benefits?
Employees who work a minimum of 30 hours per week are eligible for the health benefit plans described in this booklet.

When do benefits go into effect?
For newly hired or newly eligible employees, benefits begin on the hire date of employment.

What are the enrollment deadlines?
For newly hired employees or for those who become newly eligible during the plan year, you must enroll no later than **30 days** after your date of hire or the date of your change in eligibility status.

ADROIT

Making Changes to Your Health Benefits

Once you make benefit elections during open enrollment, you will not have another opportunity to make a change to your health benefits until the next open enrollment unless you experience a change in status, otherwise known as a “qualifying event.”

A change in status or a “qualifying event” is defined as:

- Marriage
- Divorce or legal separation
- Birth or adoption of a child
- A change in your or your spouse’s employment or insurance status
- A dependent ceasing to meet eligibility requirements
- A change in residence that affects coverage

Note: Should you experience a qualifying event and need to make a change in your coverage, you must contact your plan administrator within 30 days of the event and complete the appropriate paperwork. If you fail to notify your insurance carrier within 30 days of the event, you will not be able to make a change and will be required to wait until the next open enrollment or another qualifying event, whichever comes first.

Health Advocacy Services

As part of your benefits package, you are eligible to take advantage of Balance*Care* through eni.

Balance*Care* is a confidential and complimentary service designed to help you understand and maximize your health care benefits.

Available 24/7, Balance*Care* will connect you to a health care professional ready to assist you in managing and resolving a variety of health care issues including:

- Claims Assistance
- Referrals
- Care Coordination
- Specialty Care
- Eldercare
- Medicare
- Transportation
- Clinical Trials
- Home Health Care Services
- Hospital Planning
- Assisted Living and Finances
- Rehabilitation Services

Access to Balance*Care* is easy, with two convenient options:

Toll-Free Number	Email
877-598-8617	balancecare@eniweb.com

Brief Overview of 4 Medical Plans for 2021

Plan Coverage	NG – 2	NG-3	NG-4	NG-5
Deductible (Ind/Fam)	$2,500/$5,000	$2,850/$5,700	$3,500/$7,000	$1000/$3000
Out of Pocket Limit	$5,950/$11,900	$5,950/$11,900	$5,950/$11,900	$3,000/$6,000
Primary Care Copay	$35/Visit	$35/Visit	$35/Visit	$25/Visit
Specialist Copay	$50/Visit	$50/Visit	$50/Visit	**Designated Network:** $50/Visit **Network:** $75 Copay/Visit
Pharmacy (Tier 1 -3)	$10/$35/$60	$10/$35/$60	$10/$35/$60	$10/$35/$60
Imaging (MRI/CT Scans)	$300 Copay/Service	$300 Copay/Service	$300 Copay/Service	20% Co-Insurance after Deductible.
Emergency Room	$250 Copay/Visit	$250 Copay/Visit	$250 Copay/Visit	$250 Copay/Visit
Urgent Care	$100 Copay/Visit	$100 Copay/Visit	$100 Copay/Visit	$100 Copay/Visit
Inpatient Services	$500 Copay/admission	$500 Copay/admission	$500 Copay/admission	20% Co-Insurance after Deductible.
Outpatient Services	$50 Copay/Visit	$50 Copay/Visit	$50 Copay/Visit	$75 Copay/Visit
**Full Summary of Benefits can be located on your Paychex Flex® web portal to view.*				

Adroit Software 2021 UHC Plans

Plan 1 - NG-2/RXYH					
Employee Only			Employee + Spouse		
Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)	Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)
$451.50	$270.90	$90.30	$993.30	$270.90	$361.20
Employee + Child			Employee + Family		
Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)	Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)
$857.85	$270.90	$293.48	$1,284.64	$270.90	$564.38

Plan 2 - NG-3/RXYH					
Employee Only			Employee + Spouse		
Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)	Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)
$432.75	$259.65	$86.55	$952.05	$259.65	$346.20
Employee + Child			Employee + Family		
Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)	Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)
$822.23	$259.65	$281.29	$1,341.53	$259.65	$540.94

Plan 3 - NG-4/RXYH					
Employee Only			Employee + Spouse		
Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)	Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)
$403.72	$242.23	$80.74	$888.18	$242.23	$322.97
Employee + Child			Employee + Family		
Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)	Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)
$767.07	$242.23	$262.42	$1,251.53	$242.23	$504.65

Plan 4 - NG-5/RXYH					
Employee Only			Employee + Spouse		
Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)	Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)
$478.36	$287.02	$95.67	$1,052.39	$287.02	$382.69
Employee + Child			Employee + Family		
Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)	Total Monthly Premium	Employer Contribution	Employee contribution per pay period (based on Semi-monthly payroll cycle)
$908.88	$287.02	$310.93	$1,482.91	$287.02	$597.95

Effective June 1, 2021 to May 31, 2022

Dental Plan				
	Employee Only	Employee + Spouse	Employee + Child	Employee + Family
Monthly	$45.71	$91.42	$95.66	146.02
Semi-Monthly	$22.86	$45.71	$47.83	$73.01

Vision Plan				
	Employee Only	Employee + Spouse	Employee + Child	Employee + Family
Monthly	$8.83	$17.21	$18.10	25.15
Semi-Monthly	$4.42	$8.61	$9.05	$12.58

SUMMARY OF BENEFITS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.welcometouhc.com or by calling 1-866-673-6293. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $2,500 Individual / $5,000 Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $5,950 Individual / $11,900 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.welcometouhc.com or call 1-866-673-6293 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Specialist visit	$50 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$300 copay per service	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouhc.com.	Tier 1 - Your Lowest-Cost Option	Retail: $10 copay Mail-Order: $25 copay Specialty Drugs: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. If you use a non-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Prenotification 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. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: $35 copay Mail-Order: $87.50 copay Specialty Drugs: 40% coinsurance	Not Covered	
	Tier 3 - Your Midrange-Cost Option	Retail: $60 copay Mail-Order: $150 copay Specialty Drugs: 45% coinsurance	Not Covered	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay per visit	Not Covered	None
	Physician/surgeon fees	0% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	$250 copay per visit	$250 copay per visit	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	$100 copay per visit	Not Covered	If you receive services in addition to urgent care visit, additional copays, deductibles, or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admission	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fee	0% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay per visit	Not Covered	Limited to 30 visits per calendar year period.
	Inpatient services	$500 copay per admission	Not Covered	Limited to 30 days per calendar year period.
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	0% coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	$500 copay per admission	Not Covered	Additional copays, deductibles, coinsurance may apply.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	Limited to 60 visits per calendar year.
	Rehabilitation services	$35 copay per outpatient visit	Not Covered	Depending on the type of therapy, there is a limit of 20-36 visits per calendar year.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitative services.
	Skilled nursing care	$500 copay per admission	Not Covered	Limited to 60 days per calendar year period (combined with Inpatient Rehabilitation).
	Durable medical equipment	0% coinsurance	Not Covered	Covers 1 per type of DME (including repair/replace) every 3 years.
	Hospice services	0% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	$35 copay per visit	Not Covered	Limited to 1 exam every 2 years.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)				
• Acupuncture	• Bariatric Surgery	• Cosmetic Surgery	• Dental Care (Adult/Child)	• Glasses
• Habilitation services	• Infertility Treatment	• Long-Term Care	• Non-emergency care when traveling outside the U.S.	• Private-Duty Nursing
• Routine Foot Care	• Weight Loss Programs			

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Hearing Aids	• Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration, or 1-877-267-2323 x61565 or www.cciio.cms.gov for the U.S. Department of Health and Human Services. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-866-673-6293 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the North Carolina Department of Insurance at 1-800-546-5664 or www.ncdoi.com. Additionally, a consumer assistance program can help you file your appeal. Contact North Carolina Department of Insurance , Health Insurance Smart NC at 1-877-885-0231 or visit www.ncdoi.com.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $ 2,500
- **Specialist copayment** $50
- **Hospital (facility) copayment** $500
- **Other coinsurance** 0%

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

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,060

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $ 2,500
- **Specialist copayment** $50
- **Hospital (facility) copayment** $500
- **Other coinsurance** 0%

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

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$3,330

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $ 2,500
- **Specialist copayment** $50
- **Hospital (facility) copayment** $500
- **Other coinsurance** 0%

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

Total Example Cost	$1,900

In this example, Mia would pay:

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

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

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services.
200 Independence Avenue, SW Room 509F, HHH
Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ **(Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគេញថ្លៃ ដែលមានកត់នៅក្តង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាបរង (Summary of Benefits and Coverage, SBC) នេះ។

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

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

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.welcometouhc.com or by calling 1-866-673-6293. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $2,850 Individual / $5,700 Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $5,950 Individual / $11,900 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.welcometouhc.com or call 1-866-673-6293 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Specialist visit	$50 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$300 copay per service	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouhc.com.	Tier 1 - Your Lowest-Cost Option	Retail: $10 copay Mail-Order: $25 copay Specialty Drugs: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. If you use a non-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Prenotification 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. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: $35 copay Mail-Order: $87.50 copay Specialty Drugs: 40% coinsurance	Not Covered	
	Tier 3 - Your Midrange-Cost Option	Retail: $60 copay Mail-Order: $150 copay Specialty Drugs: 45% coinsurance	Not Covered	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay per visit	Not Covered	None
	Physician/surgeon fees	0% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	$250 copay per visit	$250 copay per visit	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	$100 copay per visit	Not Covered	If you receive services in addition to urgent care visit, additional copays, deductibles, or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admission	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fee	0% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay per visit	Not Covered	Limited to 30 visits per calendar year period.
	Inpatient services	$500 copay per admission	Not Covered	Limited to 30 days per calendar year period.
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	0% coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	$500 copay per admission	Not Covered	Additional copays, deductibles, coinsurance may apply.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	Limited to 60 visits per calendar year.
	Rehabilitation services	$35 copay per outpatient visit	Not Covered	Depending on the type of therapy, there is a limit of 20-36 visits per calendar year.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitative services.
	Skilled nursing care	$500 copay per admission	Not Covered	Limited to 60 days per calendar year period (combined with Inpatient Rehabilitation).
	Durable medical equipment	0% coinsurance	Not Covered	Covers 1 per type of DME (including repair/replace) every 3 years.
	Hospice services	0% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	$35 copay per visit	Not Covered	Limited to 1 exam every 2 years.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)				
• Acupuncture	• Bariatric Surgery	• Cosmetic Surgery	• Dental Care (Adult/Child)	• Glasses
• Habilitation services	• Infertility Treatment	• Long-Term Care	• Non-emergency care when traveling outside the U.S.	• Private-Duty Nursing
• Routine Foot Care	• Weight Loss Programs			

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Hearing Aids	• Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration, or 1-877-267-2323 x61565 or www.cciio.cms.gov for the U.S. Department of Health and Human Services. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-866-673-6293 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the North Carolina Department of Insurance at 1-800-546-5664 or www.ncdoi.com. Additionally, a consumer assistance program can help you file your appeal. Contact North Carolina Department of Insurance , Health Insurance Smart NC at 1-877-885-0231 or visit www.ncdoi.com.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $ 2,850
- **Specialist copayment** $50
- **Hospital (facility) copayment** $500
- **Other coinsurance** 0%

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

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,360

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $ 2,850
- **Specialist copayment** $50
- **Hospital (facility) copayment** $500
- **Other coinsurance** 0%

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

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$3,530

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $ 2,850
- **Specialist copayment** $50
- **Hospital (facility) copayment** $500
- **Other coinsurance** 0%

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

Total Example Cost	$1,900

In this example, Mia would pay:

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

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

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services.
200 Independence Avenue, SW Room 509F, HHH
Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ **(Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគេញថ្លៃ ដែលមានកត់នៅក្តង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាបរង (Summary of Benefits and Coverage, SBC) នេះ។

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

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

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.welcometouhc.com or by calling 1-866-673-6293. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $3,500 Individual / $7,000 Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $5,950 Individual / $11,900 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.welcometouhc.com or call 1-866-673-6293 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay per visit	Not Covered	None
	Specialist visit	$50 copay per visit	Not Covered	None
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$300 copay per service	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouhc.com.	Tier 1 - Your Lowest-Cost Option	Retail: $10 copay Mail-Order: $25 copay Specialty Drugs: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. If you use a non-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Prenotification 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. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: $35 copay Mail-Order: $87.50 copay Specialty Drugs: 40% coinsurance	Not Covered	
	Tier 3 - Your Midrange-Cost Option	Retail: $60 copay Mail-Order: $150 copay Specialty Drugs: 45% coinsurance	Not Covered	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay per visit	Not Covered	None
	Physician/surgeon fees	0% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	$250 copay per visit	$250 copay per visit	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	$100 copay per visit	Not Covered	If you receive services in addition to urgent care visit, additional copays, deductibles, or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admission	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fee	0% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay per visit	Not Covered	Limited to 30 visits per calendar year period.
	Inpatient services	$500 copay per admission	Not Covered	Limited to 30 days per calendar year period.
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	0% coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	$500 copay per admission	Not Covered	Additional copays, deductibles, coinsurance may apply.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	Limited to 60 visits per calendar year.
	Rehabilitation services	$35 copay per outpatient visit	Not Covered	Depending on the type of therapy, there is a limit of 20-36 visits per calendar year.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitative services.
	Skilled nursing care	$500 copay per admission	Not Covered	Limited to 60 days per calendar year period (combined with Inpatient Rehabilitation).
	Durable medical equipment	0% coinsurance	Not Covered	Covers 1 per type of DME (including repair/replace) every 3 years.
	Hospice services	0% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	$35 copay per visit	Not Covered	Limited to 1 exam every 2 years.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)				
• Acupuncture	• Bariatric Surgery	• Cosmetic Surgery	• Dental Care (Adult/Child)	• Glasses
• Habilitation services	• Infertility Treatment	• Long-Term Care	• Non-emergency care when traveling outside the U.S.	• Private Duty Nursing
• Routine Foot Care	• Weight Loss Programs			

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Hearing Aids	• Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration, or 1-877-267-2323 x61565 or www.cciio.cms.gov for the U.S. Department of Health and Human Services. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-866-673-6293 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the North Carolina Department of Insurance at 1-800-546-5664 or www.ncdoi.com. Additionally, a consumer assistance program can help you file your appeal. Contact North Carolina Department of Insurance , Health Insurance Smart NC at 1-877-885-0231 or visit www.ncdoi.com.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $ 3,500
- **Specialist copayment** $50
- **Hospital (facility) copayment** $500
- **Other coinsurance** 0%

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

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,060

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

- **The plan's overall deductible** $ 3,500
- **Specialist copayment** $50
- **Hospital (facility) copayment** $500
- **Other coinsurance** 0%

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

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$4,130

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

- **The plan's overall deductible** $ 3,500
- **Specialist copayment** $50
- **Hospital (facility) copayment** $500
- **Other coinsurance** 0%

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

Total Example Cost	$1,900

In this example, Mia would pay:

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

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

Notice of Non-Discrimination

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services.
200 Independence Avenue, SW Room 509F, HHH
Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ **(Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគេញថ្លៃ ដែលមានកត់នៅក្តង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាបរង (Summary of Benefits and Coverage, SBC) នេះ។

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

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

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.welcometouhc.com or by calling 1-800-782-3158. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Designated Network and Network: $1,000 Individual / $3,000 Family Non-Network: $2,000 Individual / $6,000 Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Designated Network and 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 in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover, penalties for failure to obtain Prenotification for services , per occurence deductible , copays and prescription drugs.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.welcometouhc.com or call 1-800-782-3158 for a list of network providers.	You pay the least if you use a provider in the Designated network. You pay more if you use a provider in the network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Designated Network Provider (You will pay the least)	Network Provider	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit. Deductible does not apply	$25 copay per visit. Deductible does not apply	40% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Specialist visit	$50 copay per visit, deductible does not apply	$75 copay per visit, deductible does not apply	40% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Preventive care/screening /immunizatio-n	No Charge	No Charge	30% coinsurance	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: No Charge Hospital-Based: 20% coinsurance, deductible does not apply	Free Standing Provider: No Charge Hospital-Based: 20% coinsurance, deductible does not apply	30% coinsurance	Deductible does not apply to Preferred and Network.
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: 20% coinsurance Hospital-Based: 20% coinsurance	Free Standing Provider: 20% coinsurance Hospital-Based: 20% coinsurance	40% coinsurance	$250 Free Standing Provider per occurrence deductible applies prior to the overall deductible. $500 Hospital-Based per occurrence deductible applies prior to the overall deductible.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Designated Network Provider (You will pay the least)	Network Provider	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouhc.com.	Tier 1 - Your Lowest-Cost Option	Deductible does not apply. Retail: $10 copay Mail-Order: $25 copay Specialty Drugs: $10 copay	Deductible does not apply. Retail: $10 copay Mail-Order: $25 copay Specialty Drugs: $10 copay	Deductible does not apply. Retail: $10 copay Specialty Drugs: $10 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. If you use a non-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization 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. Out of Pocket limit: $5000 Ind / $10000 Fam per calendar year. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Deductible does not apply. Retail: $35 copay Mail-Order: $87.50 copay Specialty Drugs: 40% coinsurance	Deductible does not apply. Retail: $35 copay Mail-Order: $87.50 copay Specialty Drugs: 40% coinsurance	Deductible does not apply. Retail: $35 copay Specialty Drugs: 40% coinsurance	
	Tier 3 - Your Midrange-Cost Option	Deductible does not apply. Retail: $60 copay Mail-Order: $150 copay Specialty Drugs: 45% coinsurance	Deductible does not apply. Retail: $60 copay Mail-Order: $150 copay Specialty Drugs: 45% coinsurance	Deductible does not apply. Retail: $60 copay Specialty Drugs: 45% coinsurance	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center /Physician's Office: 20% coinsurance Hospital-Based: 20% coinsurance	Ambulatory Surg Center /Physician's Office: 20% coinsurance Hospital-Based: 20% coinsurance	40% coinsurance	Preauthorization required for Non-Network or benefit reduces to 50% of allowed. $500 Hospital-Based per occurrence deductible applies prior to the overall deductible.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Designated Network Provider (You will pay the least)	Network Provider	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay per visit, deductible does not apply	$250 copay per visit, deductible does not apply	$250 copay per visit, deductible does not apply	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	None
	Urgent care	$100 copay per visit, deductible does not apply	$100 copay per visit, deductible does not apply	40% coinsurance	If you receive services in addition to urgent care visit, additional copays, deductibles, or coinsurance may apply may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	40% coinsurance	Preauthorization required for Non-Network or benefit reduces to 50% of allowed. $500 Inpatient Stay per occurrence deductible applies prior to the overall deductible.
	Physician/surgeon fee	20% coinsurance	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$75 copay per visit, deductible does not apply	$75 copay per visit, deductible does not apply	40% coinsurance	Limited to 30 visits per calendar year period. Preauthorization required for Non-Network or benefit reduces to 50% of allowed.
	Inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	Limited to 30 days per calendar year period. Preauthorization required for Non-Network or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	No Charge	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Designated Network Provider (You will pay the least)	Network Provider	Non-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	40% coinsurance	Inpatient preauthorization for Non-Network may apply or benefit reduces to 50% of allowed. $500 Inpatient Stay per occurrence deductible applies prior to the overall deductible.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	40% coinsurance	Limited to 60 visits per calendar year. Preauthorization required for Non-Network or benefit reduces to 50% of allowed.
	Rehabilitation services	$25 copay per outpatient visit, deductible does not apply	$25 copay per outpatient visit, deductible does not apply	40% coinsurance	Depending on the type of therapy, there is a limit of 20-36 visits per calendar year.
	Habilitative services	Not Covered	Not Covered	Not Covered	No coverage for Habilitative services.
	Skilled nursing care	20% coinsurance	20% coinsurance	40% coinsurance	Limited to 60 days per calendar year (combined with Inpatient Rehabilitation). Preauthorization required for Non-Network or benefit reduces to 50% of allowed.
	Durable medical equipment	20% coinsurance	20% coinsurance	40% coinsurance	Covers 1 per type of DME (including repair/replace) every 3 years. Preauthorization required for Non-Network DME over $1000 or no coverage.
	Hospice services	20% coinsurance	20% coinsurance	40% coinsurance	Inpatient Preauthorization required for Non-Network or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam	$25 copay per visit, deductible does not apply	$25 copay per visit, deductible does not apply	40% coinsurance	Limited to 1 exam every 2 years.
	Children's glasses	Not Covered	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	No coverage for Children's dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)				
• Acupuncture	• Bariatric Surgery	• Cosmetic Surgery	• Dental Care (Adult/Child)	• Glasses
• Habilitation services	• Infertility Treatment	• Long-Term Care	• Non-emergency care when traveling outside the U.S.	• Private-Duty Nursing
• Routine Foot Care	• Weight Loss Programs			

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Hearing Aids	• Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration, or 1-877-267-2323 x61565 or www.cciio.cms.gov for the U.S. Department of Health and Human Services. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-800-782-3158 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the North Carolina Department of Insurance at 1-800-546-5664 or www.ncdoi.com. Additionally, a consumer assistance program can help you file your appeal. Contact North Carolina Department of Insurance , Health Insurance Smart NC at 1-877-885-0231 or visit www.ncdoi.com.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-782-3158 .
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3158 .
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-782-3158 .
Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-800-782-3158 .

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $ 1,000
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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

Total Example Cost	$12,800
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,560

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

- **The plan's overall deductible** $ 1,000
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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

Total Example Cost	$7,400
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$1,330

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

- **The plan's overall deductible** $ 1,000
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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

Total Example Cost	$1,900
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$700
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,000

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

Notice of Non-Discrimination

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services.
200 Independence Avenue, SW Room 509F, HHH
Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ **(Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគេញថ្លៃ ដែលមានកត់នៅក្តង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាបរង (Summary of Benefits and Coverage, SBC) នេះ។

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

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

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

Medical Plans Summary

	Bronze Essential	Silver Proactive		
		Tier 1-Preferred	Tier 2-Enhanced	Tier 3-Standard
Annual Deductible & Out of Pocket Maximum-In Network				
Deductible (Individual/Family)	$6,850/$13,700	$0/$0	$5,500/$11,000	$5,500/$11,000
OOP (Individual/Family)	$7,150/$14,300	$7,150/$14,300	$7,150/$14,300	$7,150/$14,300
General Visits				
PCP	$50 Copay	$30 Copay	$40 Copay	$50 Copay
Specialist	$100 Copay	$60 Copay	$80 Copay	$100 Copay
Urgent care	$150 Copay	$100 copay/visit	$100 copay/visit	$100 copay/visit
Emergency Room	$500 Copay	$550 copay/visit	$550 copay/visit	$550 copay/visit
Inpatient Hospitalization	Deductible then $700/day	$500/day; max of 5 copay/admission	Subject to deductible and $900/day; max of 5 copay/admission	Subject to deductible and $1,300/day; max of 5 copay/admission
Outpatient Hospitalization	Deductible then $750 Copay	$250 Copay/visit	Subject to deductible and $750 copay/visit	Subject to deductible and $1,250 copay/visit
Prescription Coverage- In-network				
Generic Drugs (retail)	$15 copay	$15 copay	$15 copay	$15 copay
Preferred brand	50% up to $500 Max/prescription	50% co-ins with a max member payment of $400/prescription fill	50% co-ins with a max member payment of $400/prescription fill	50% co-ins with a max member payment of $400/prescription Fill
Non-preferred drugs	50% up to $500 max/prescription	50% co-ins with a max member payment of $500/prescription fill	50% co-ins with a max member payment of $500/prescription fill	50% co-ins with a max member payment of $500/prescription fill
Specialty drugs	50% up to $1,000 max/prescription	50%co-ins with a max member payment of $1000/prescription fill	50%co-ins with a max member payment of $1000/prescription fill	50%co-ins with a max member payment of $1000/prescription fill

Note: This is a summary of benefits and rates for each option. Complete details of the benefits and rates are contained in the carriers' plan documents. In the event of a conflict between this summary and the carriers' plan documents, the carriers' plan documents are controlling. The rates are based on the census submitted to Paychex Insurance Agency by your employer. Carriers may change rates after enrollment if final enrollment differs from census.

Other Programs you're able to participate in:

-Health Savings Account through Paychex

-Gym Reimbursement Program through UHC

PAYCHEX® INSURANCE Agency INC.

Paychex HSA

A Smarter Way to Pay for Health Care

As health-care costs continue to soar, finding ways to offer affordable health benefits to your employees is a persistent challenge. A Paychex Health Savings Account (HSA) is one benefit that can help both your business and your employees save money.

The Paychex HSA is a tax-advantaged savings account used in combination with a high- deductible health plan (HDHP) to provide your employees a way to manage their health-care costs. An HSA offers employees a budgeting tool that helps pay for eligible out-of-pocket medical expenses not covered by a company benefit plan.

How HSAs Work

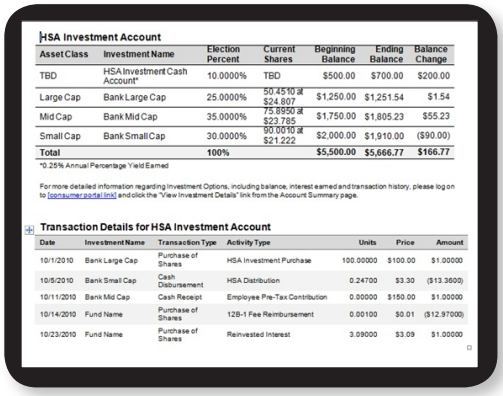
Predetermined contributions are set aside before payroll taxes are calculated. So, as the employer, you pay less in payroll taxes, while participating employees have less deducted for taxes and may see more take-home pay. Employers and other third parties can also contribute to the account.

When a participant incurs an eligible expense, like a co-payment at a provider's office, a pharmacy bill, or vision-care expenses, they can use their Paychex prepaid benefits card or pay online using funds from their HSA account. Visit the Paychex website for a list of eligible expenses.

If the employee doesn't have enough money in their HSA to cover a medical expense, they can make a partial payment, and then pay the difference using another method. Unlike a flexible savings account (FSA), there is no "use it or lose it" condition at the end of the year (or grace period). Any unused funds remain in the account and continue to accrue interest until used.

More information on HSA plans can be found on the U.S. Department of Treasury website at www.treas .gov (search on HSA).

Powered by: evolution1®



HSA Investment Account

Asset Class	Investment Name	Election Percent	Current Shares	Beginning Balance	Ending Balance	Balance Change
TBD	HSA Investment Cash Account*	10.0000%	TBD	$500.00	$700.00	$200.00
Large Cap	Bank Large Cap	25.0000%	50.4510 at $24.807	$1,250.00	$1,251.54	$1.54
Mid Cap	Bank Mid Cap	35.0000%	75.8950 at $23.785	$1,750.00	$1,805.23	$55.23
Small Cap	Bank Small Cap	30.0000%	90.0010 at $21.222	$2,000.00	$1,910.00	($90.00)
Total		100%		$5,500.00	$5,666.77	$166.77

*0.25% Annual Percentage Yield Earned

For more detailed information regarding Investment Options, including balance, interest earned and transaction history, please log on to [consumer portal link] and click the "View Investment Details" link from the Account Summary page.

Transaction Details for HSA Investment Account

Date	Investment Name	Transaction Type	Activity Type	Units	Price	Amount
10/1/2010	Bank Large Cap	Purchase of Shares	HSA Investment Purchase	100.00000	$100.00	$1.00000
10/5/2010	Bank Small Cap	Cash Disbursement	HSA Distribution	0.24700	$3.30	($13.3600)
10/11/2010	Bank Mid Cap	Cash Receipt	Employee Pre-Tax Contribution	0.00000	$150.00	$1.00000
10/14/2010	Fund Name	Purchase of Shares	12B-1 Fee Reimbursement	0.00100	$0.01	($12.97000)
10/23/2010	Fund Name	Purchase of Shares	Reinvested Interest	3.09000	$3.09	$1.00000

Robust online portal empowers participants, providing everything they need to know about their account, with an industry-leading design for quick and easy navigation.

PAYCHEX®

Features and Functionality

By offering the Paychex HSA to your employees, you can help fight rising health-insurance costs, offer greater depth and flexibility in your benefits package, and promote healthy lifestyles with these powerful features:

- Health FSA, HSA, and HRA accounts are fully integrated in one platform, along with custodial banking services.
- Flexible contribution schedules available.
- Web-based, fully integrated portals provide 24/7 access to account information.*
- Monthly reports generate automatically and email alerts direct recipients to secure portals for viewing, creating a virtually paper-free administration process.
- Employees can access funds through online distribution requests, or by using a convenient benefits debit card.
- Distributions can be sent to employees by direct deposit or check.
- Employees can view account details, request distributions, update addresses, view statements, change beneficiaries, or allocate funds into an array of mutual funds using the convenient online portal.
- Easy online enrollment creates an HSA account with direct deposit and investment accounts.
- Automated communication and email alerts help to ensure consistent messaging.
- Contributions deposited to FDIC-insured cash and interest-bearing accounts.

*24/7 account access generally means 24 hours a day, 7 days a week, except when systems are unavailable due to scheduled maintenance.

Robust participant portal provides detailed account information, with state-of-the-art security and quick, intuitive navigation.

To find out how a Paychex HSA could benefit your business and your employees, call our toll-free number or visit our website.

PAYCHEX®

877-266-6850

www.paychex.com/HSA

3 Ways Employees Can Save on Taxes:

1. ***Fund account via tax-deductible contributions.***
2. ***Tax-free growth on invested funds.***
3. ***Tax-free withdrawals for qualified medical expenses.***

160271 6/13 CT

A new interactive experience makes managing your health easy and fun

Introducing Rally℠, brought to you by UnitedHealthcare

Introducing an easier way for you to eat better, move more, be more informed and get started on personal Missions to help improve your health.

Rally is a user-friendly digital experience on **myuhc.com**® that will engage you in a new way by using technology, gaming and social media to help you understand, learn and support you on your health journey.

What Is Rally?

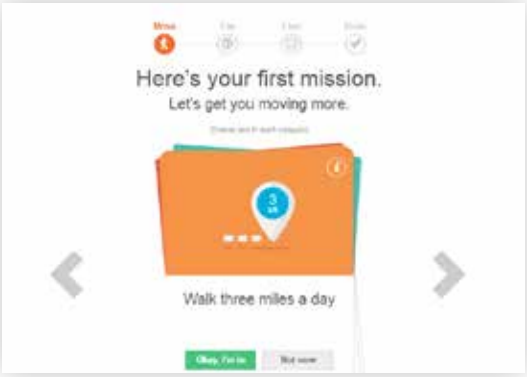
With the online Rally Health Survey, personalized Missions, rewards and connections to wearables like Fitbit®, Jawbone® and more, we make it easier for you to get motivated to be healthier. When you sign up for Rally, the first thing you'll learn is your Rally Health Age, which tells you how your body is feeling right now. Then you can start exploring all the great digital tools that may help you make healthier choices based on your life, schedule and needs.

Rally offers a personalized interactive experience:

- Challenges and Communities
- Missions and rewards
- Lifestyle plans
- Intuitive Health Survey

RALLY℠

UnitedHealthcare®



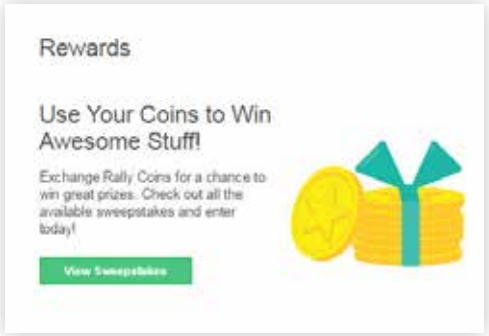
Get Started: Personal Missions

Once you have completed the Health Survey, we have the data we need to suggest action steps or "Missions." "Move," "Eat," "Feel," and "Care" Missions are interactive and provide choices that may help improve or maintain your health. They're also linked to promotions, reminders and tracking accomplishments, giving you just the push you need to keep going.

Tracking Is Simple, Fun and Full of Rewards

Health trackers monitoring weight loss, physical activity and more are tightly integrated with motivating messages and personally relevant information, to keep you inspired. You can also connect with consumer wearables like FitBit and JawBone as well as mobile access.

To help you create new healthy habits, coins are awarded every time you engage — even in small ways — essentially rewarding you every time a health or tracking activity takes place. Coins can be used to enter sweepstakes, and an email notification tells if a reward activity is complete or if you have registered for a sweepstakes.



Coins are earned every time a health or tracking activity takes place.

Making Healthy Connections

With Rally, you can also join an online challenge, share your accomplishments with others through moderated health communities, choose an Avatar, connect with a personal wellness coach or join a competition to increase the fun.

RALLY℠

UnitedHealthcare®

All trademarks are property of the respective owners. Participation in the health survey is voluntary. Your health survey responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities. **This program should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room.** The information provided through the program is for informational purposes only and provided as part of your health plan. The wellness team cannot diagnose problems or recommend treatment and is not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. The program is not an insurance program and may be discontinued at any time. You are receiving this email from your employer in connection with a product or service offered by UnitedHealthcare. If you have questions about your account, claims or benefits or would like additional information, please visit myuhc.com (or your member website) or call the toll-free number on the back of your health plan ID card. If you do not wish to receive this type of information from your employer in the future, please contact your Employer's Benefits Administrator.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

100-15545 11/25-2014 © 2014 United HealthCare Services, Inc.

PAYCHEX®
INSURANCE Agency INC.