



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mylowesbenefits.com or by calling 1-888-474-6365.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: \$1,750 Individual* / \$3,500 Family Non-Network: \$1,750 Individual* / \$3,500 Family Per calendar year. Does not apply to services listed below as "No Charge".	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Medical- Network: \$6,550 Individual / \$13,100 Family Non-Network: \$6,550 Individual / \$13,100 Family	The <u>out-of-pocket limit</u> is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , balanced-billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a <u>network of providers</u> ?	No, this plan does not use a <u>network of providers</u> .	This plan treats <u>providers</u> the same in determining payment for the same services.
Do I need a referral to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on Page 7. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-800-926-7426 or visit us at www.myuhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call the number above to request a copy.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Employee/Family | Plan Type: IND



- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- Your costs are the same no matter which provider you see.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None
	Specialist visit	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None
	Other practitioner office visit	50% Coinsurance After Deductible	50% Coinsurance After Deductible	Cost Share applies for Manipulative (Chiropractic) Care. Spinal manipulation services are limited to a max payment of \$500 per calendar year
	Preventive care/screening/immunization	No Charge	No Charge	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None
	Imaging (CT/PET scans, MRIs)	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.caremark.com.</p>	Tier 1 - Your Lowest-Cost Option	Retail: 50% Coinsurance After Deductible Mail Order: 50% Coinsurance After Deductible	Retail: N/A Mail Order: N/A	3-30 day refills at retail for maintenance drugs.
	Tier 2 - Your Midrange-Cost Option	Retail: 50% Coinsurance After Deductible Mail Order: 50% Coinsurance After Deductible	Retail: N/A Mail Order: N/A	None
	Tier 3 - Your Highest-Cost Option	Retail: 50% Coinsurance After Deductible Mail Order: 50% Coinsurance After Deductible	Retail: N/A Mail Order: N/A	None
	Tier 4 - Additional High-Cost Option	Retail: 50% Coinsurance After Deductible Mail Order: 50% Coinsurance After Deductible	Retail: N/A Mail Order: N/A	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None
	Physician/surgeon fees	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None
If you need immediate medical attention	Emergency room services	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None
	Emergency medical transportation	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None
	Urgent care	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None.
	Physician/surgeon fee	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None
	Mental/Behavioral health inpatient services	50% Coinsurance After Deductible	50% Coinsurance After Deductible	none
	Substance use disorder outpatient services	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None
	Substance use disorder inpatient services	50% Coinsurance After Deductible	50% Coinsurance After Deductible	none
If you are pregnant	Prenatal and postnatal care	50% Coinsurance After Deductible	50% Coinsurance After Deductible	Your cost in this category includes physician delivery charges. Routine prenatal care is covered at No Charge
	Delivery and all inpatient services	50% Coinsurance After Deductible	50% Coinsurance After Deductible	Prior authorization for out of network if delivery exceeds the 48/96 time frame. Your cost for inpatient services only. For physician delivery charges, see pre/postnatal care. If prior authorization is not received for out of network benefit is reduced by 30%.

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	50% Coinsurance After Deductible	50% Coinsurance After Deductible	120 visits per calendar year
	Rehabilitation services	50% Coinsurance After Deductible	50% Coinsurance After Deductible	60 visits per calendar year combined for Physical, Speech and Occupational Therapy. Prior authorization required for Physical, Occupational and Speech therapy. If prior authorization is not received benefit is reduced by 30%
	Habilitation services	50% Coinsurance After Deductible	50% Coinsurance After Deductible	60 visits for habilitative occupational, physical and speech therapy per member per calendar year; clinical review after the first visit; precertification is required for coverage. If prior authorization is not received benefit is reduced by 30%.
	Skilled nursing care	50% Coinsurance After Deductible	50% Coinsurance After Deductible	120 days per calendar year.
	Durable medical equipment	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None
	Hospice service	50% Coinsurance After Deductible	50% Coinsurance After Deductible	None
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	Not covered
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Child dental check-up Child routine vision exam (i.e. refraction) Child vision glasses 	<ul style="list-style-type: none"> Cosmetic Surgery Dental Care (Adult) Habilitation services Infertility treatment 	<ul style="list-style-type: none"> Long-term care Non-emergency care when traveling outside the U.S. Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> • Adult routine vision exam (i.e. refraction) • Bariatric Surgery limitations may apply 	<ul style="list-style-type: none"> • Chiropractic care limitations may apply • Hearing aids limitations may apply 	<ul style="list-style-type: none"> • Private-duty nursing limitations may apply • Routine foot care limitations may apply

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 1-877-502-6272. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us at 1-800-926-7426 or visit www.myuhc.com.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does not meet the minimum value standard for the benefits it provides.


Language Access Services:

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

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

About these Coverage Examples:

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



This is not a cost estimator.

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

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

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$2,870
- Patient pays: \$4,670

Sample care costs:

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

Patient pays:

Deductibles	\$1,750
Copays	\$0
Coinsurance	\$2,770
Limits or exclusions	\$150
Total	\$4,670

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

- Amount owed to providers: \$5,400
- Plan pays: \$1,810
- Patient pays: \$3,590

Sample care costs:

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

Patient pays:

Deductibles	\$1,750
Copays	\$0
Coinsurance	\$1,760
Limits or exclusions	\$80
Total	\$3,590

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example Show

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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