2024 SUMMARY PLAN DESCRIPTION

UNIVERSITY OF MIAMI PREVENTIVE CARE MEDICAL PLAN

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This contains only a summary of preventive care plan benefits offered to anyone who is not eligible to enroll in the UM/Aetna health plan.

Foreign Language Statement

This SPD contains a summary in English of your plan rights and benefits under this employer's group health plan. If you have difficulty understanding any part of this document, contact HR-Total Rewards at 305-284-3004.

Este documento contiene un resumen en inglés de los derechos y beneficios bajo el plan de salud de este Empleador. Si tiene dificultades entendiendo cualquier parte de este documento, comuníquese con HR-Total Rewards al 305-284-3004.

Preventive Care Medical Plan

What the Plan Can Do For You

The University of Miami's Preventive Care Medical Plan is offered to anyone who is not eligible to enroll in the UM/Aetna health plan. Coverage will begin on your date of hire.

Enrollment must be completed via benefits enrollment in Workday. If enrollment is not completed within 15 days after date of hire, you will not be eligible to enroll until the following Open Enrollment period unless a Qualified Status Change occurs.

Health care premiums are deducted on a pre-tax basis with salary reduction equal to the current cost of coverage selected. Once elected, the employee's income, which is subject to Federal income tax and Social Security withholding (FICA), will be reduced. This may affect future amounts received from Social Security. Except for Qualified Status Changes, elections for group health insurance may not be changed during the Plan year.

The amount of your premium will depend on the plan option you choose and whether you elect to cover eligible family members.

Dependent Coverage

Eligible dependents may be enrolled at the time the employee enrolls. Enrollments can also occur during an Open Enrollment period or at the time of a Qualified Status Change.

A dependent is defined as the child of the subscriber, provided that the following conditions apply:

- The child is the biological child or stepchild of the subscriber or legally adopted child (from the moment of placement in compliance with Florida law) in the custody of the subscriber; written evidence of adoption must be furnished to the Plan Administrator upon request. Except as specifically noted, the child must meet all requirements for eligibility listed herein:
    1. The child has not reached the Limiting Age which is defined in this Section as the last day of the birth month in which he/ she turns age 26 (except for paragraph b) below);
    2. Coverage will be extended where the child is either physically incapacitated or mentally challenged, is not capable of supporting him or herself and regularly receives over 50% of his/her support from the subscriber, provided that the dependent was covered under the University's Preventive Care Medical Plan prior to reaching the age 26.
        a. Proof of incapacitation or mental challenge (e.g. written documentation from the child's physician) is required for coverage after the child has reached the age 26.
        b. Coverage for dependent child who is physically incapacitated or mentally challenged may be discontinued at the end of the calendar month in which the child reaches age 26 and/ or:
            i. the child is no longer disabled; or
            ii. the child is capable of supporting him or herself; or
            iii. the child no longer receives more than 50% of his/her support from the subscriber; or
            iv. the child receives less than 50% of his/her support from the subscriber and the subscriber is no longer obligated to provide medical care for said child by court order.
    3. Coverage will be extended where the subscriber has agreed to regularly provide medical care for the child by court order regardless of adoption.
    4. Coverage will be extended where a Qualified Medical Child Support Order (QMSCO) exists; Whether or not said child resides with the employee.
    5. A newborn child of a covered dependent child is ineligible for medical coverage after delivery

- Your legally recognized spouse.

For all covered dependents, proof of relationship is required in the applicable form of a government issued marriage license, government issued birth certificate, divorce decree, etc. The University reserves the right to audit employee records and request these documents at any time if not already on file. If the documents cannot be provided to the University within a reasonable amount of time when requested, we reserve the right to terminate coverage for the applicable dependent.

Qualifying Status Changes

IRS Section 125 rules regarding pre-tax premium plans do not allow for enrollment, additions, changes, or cancellations except with the occurrence of a Qualifying Status Change (QSC) event, followed by written application for a change within 30 days or during the annual open enrollment period. The federal government determines the events that qualify as QSCs, and this list is subject to periodic change.

After declining health coverage. If you are declining enrollment in the Preventive Care Plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in these plans in the future, provided that you request enrollment within 30 days after your other coverage ends.

New dependents. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

The following are additional events, but not necessarily all, valid QSC events:

- Loss of coverage through Medicaid or other SCHIP or new enrollment in Medicaid or other SCHIP
- Change in employment status of employee, spouse, or dependent affecting insurance coverage including:
    1. Termination of spouse's or dependent's employment
    2. Change from part-time to full-time status or vice versa

An enrollee wishing to change a benefit election on the basis of a QSC must complete the following steps:

1. Report the QSC to HR-Total Rewards via Workday and requesting the corresponding change to benefits.
2. Provide required supporting documentation (e.g. government issued marriage certificate, government issued birth certificate, divorce decree, etc.). QSCs cannot be processed without the corresponding required supporting documentation.
3. HR-Total Rewards must receive the request via Workday and related documentation within 30 days of the QSC event or the request for change(s) will be denied and cannot be made until the next annual open enrollment period. *NOTE: The enrollee should report the event immediately if supporting documentation is not readily available; a period of 60 days may be allowed to provide the necessary documentation. For Medicaid or other SCHIP events, a period of 60 days is allowed to make a change.*

Termination of dependents. If you have a spouse or child who no longer qualifies for coverage, you are required to notify HR-Total Rewards via Workday within 30 days of the event in order to remove the individual from coverage.

Non Compliance. Falsifying information/documentation in order to obtain/continue insurance coverage is considered a dishonest act and could lead to disciplinary action and criminal prosecution. Inadvertent or negligent failures to update or correct information related to eligibility of an employee's listed dependent are also subject to penalty. Employees are responsible for updating dependent information within 30 calendar days of the occurrence of any event affecting

eligibility; for example, a divorce severing a marriage. The University may impose a financial penalty, including, but not limited to, repayment of all insurance premiums the university made on behalf of the ineligible dependent and/or any claims paid by the insurance companies. Disciplinary action up to and including dismissal may also be imposed if deemed appropriate.

To make an enrollment change based on a QSC, the QSC must result in a gain or loss of eligibility for coverage, and general consistency rules must be met. For example, if an enrollee with family health insurance coverage is divorced and no longer has dependents, that enrollee may change from family to individual coverage but cannot cancel enrollment in health insurance because the QSC merely changes the level of coverage eligibility. Cancellation would not be consistent with the nature of the QSC event.

Health Insurance Portability and Accountability Act (HIPAA), Protected Health Information (PHI) and Genetic Information Nondiscrimination (GINA)

The UnitedHealthcare plan conforms to the standards for protection of individual private health information (PHI). Neither the University of Miami nor UnitedHealthcare condition enrollment in the plan based on an individual's health status. Medical claims are submitted according to electronic data standards required by the act. The University of Miami subscribes to the use of the minimum necessary standard when it comes to an individual's PHI. Access to PHI must be authorized in writing by the individual employee or representative. The plan may not discriminate in health coverage based on genetic information. The plan may not use genetic information to adjust premium or contribution amounts, request or require an individual or their family members to undergo a genetic test, or request, require, or purchase genetic information for underwriting purposes or prior to or in connection with an individual's enrollment in the plan.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Glossary of Common Terms

To better understand your benefits, you should be aware of the meaning of the following terms:

Coinsurance

Your share of the costs of a covered healthcare expense calculated as a percent based on the contracted UnitedHealthcare rate you pay for services after your deductible is met.

Deductible
The dollar amount you must pay before the plan will pay for certain services before the insurer begins to make payments for covered medical services.

Out-Of-Pocket Limit
The maximum dollar amount you are required to pay out of pocket during the calendar year. When the amount of combined covered expenses paid by you and/or all your covered dependents (family) satisfies the out-of-pocket limit, UnitedHealthcare will pay 100% of covered expenses for the remainder of the calendar year.

What is Covered

Health Care Benefits will be paid for:

- Annual wellness exam
- Well women exams
- Measurements of your weight, blood pressure, glucose (blood sugar) and cholesterol
- Immunization vaccines, such as flu shots
- Well-baby and well-child visits
- Cancer screenings, such as mammograms and colonoscopies
- Preventive Lab, X-Ray or Preventive test
- Mandated over the counter drugs
- Women's health contraceptives

What is Not Covered

Health Care Benefits will not be paid for:

- Routine dental services and supplies
- Sick visits
- Outpatient surgery
- Hospitalization
- Doctor visits for anything other than annual preventive care

Well Child Care

Well child care benefits are provided on an outpatient basis for a covered dependent child and include periodic examination (which may include a history, physical examinations, developmental assessment and anticipated guidance) necessary to monitor the normal growth and development of an infant, limited to oral and/or intramuscular injection for the purpose of immunization; and laboratory tests.

Preventive Care

All services considered preventive and therefore covered at 100% under the Patient Protection and Affordable Care Act are covered. For a complete list, visit healthcare.gov/coverage/preventive-care-benefits.

UnitedHealthcare

The preventive care medical plan is administered by UnitedHealthcare on behalf of the University of Miami.

Monthly health care premium amounts for the current calendar year can be found on the HR-Total Rewards website located at benefits.miami.edu.

This plan allows you and your covered dependents a full range of preventive care benefits when using UnitedHealthcare In-Network providers.

Service	In Network Provider	Out of Network Provider
PRIMARY CARE (PCP):		
Preventive Care Visit	Covered 100%	Not Covered
IMMUNIZATIONS:		
Preventive Care	Covered 100%	Not Covered
LABS, X-RAY, TESTING:		
Preventive Care	Covered 100%	Not Covered
PHARMACY:		
Mandated over the counter drugs	Covered 100%	Not Covered
Women's health contraceptives	Covered 100%	Not Covered

** This is a summary only and not intended as a complete description of covered services.*

Pharmacy

In accordance with the Patient Protection and Affordable Care Act, many generic oral contraceptives and some contraceptive devices are covered at 100% by the plan. Please visit UnitedHealthcare.com for a complete list.

Termination and Continuation of Coverage

Coverage for you and your insured dependents will terminate when your employment terminates, you enter the Armed Forces, you die or when the master contract terminates. Insurance for dependents will also terminate when your coverage terminates or when they are no longer eligible dependents as described. Coverage will end the last day of the month in which you are no longer a full-time regular or part-time employee.

Introduction

This SPD contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This is a general explanation of COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

Important Information About Your Cobra Continuation Coverage Rights

What is continuation coverage?

Federal law requires that most group health plans including this Plan give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee or retired employee covered

under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.
Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

How long will continuation coverage last?
In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries. Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?
If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify HR-Total Rewards of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability
An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. Premiums for qualified beneficiaries who are determined by Social Security to be disabled may be increased from 102% to 150% of the full cost of coverage if the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan of that fact within 31 days after the Social Security Administration’s determination.

Second Qualifying Event
An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits, or a dependent child's ceasing to be eligible for coverage as a

dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

HealthEquity/WageWorks, Inc. is our COBRA administrator. To elect continuation coverage, you must complete the HealthEquity/WageWorks Election Form that was mailed to you and furnish it according to the directions of the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that failure to continue your group health coverage will affect your future rights under Federal law. First, you can lose the right to avoid having pre-existing condition exclusion applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact *the* Plan Administrator to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first of the month for that coverage period. The Plan will not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments
Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is postmarked before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all subsequent periodic payments for continuation coverage should be sent to:

HealthEquity/WageWorks, Inc.
P.O. Box 14055
Lexington, Kentucky 40512-4055

For more information
If you have any questions concerning the information in the notice, your rights to coverage, you should contact HR-Total Rewards at 305-284-3004.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability ACT (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes
In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

University of Miami
HR-Total Rewards
P.O. Box 248106
Coral Gables, Florida 33124-2902
305-284-3004

Claims

UnitedHealthcare is the claims administrator for the University of Miami Preventive Care Medical Plan. Faculty and staff receiving a bill for covered services from a UnitedHealthcare provider should do the following:

In-Network
1. Make a copy of your UnitedHealthcare ID card (front and back) and a copy of the bill. Send a copy of both to the provider who is sending you the bill. This will alert the provider to bill the insurance company. Provide an explanation of the issue.
2. Follow the same procedures as in step 1 but mail the information to the UnitedHealthcare claims address on the back of your UnitedHealthcare ID card. Provide an explanation of the issue.

Qualified Medical Child Support Order (QMCSO)

Participants may obtain a copy of the plan's procedures without cost by contacting HR-Total Rewards.

Discrimination is Against the Law

The University of Miami complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The University does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The University of Miami:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:
Qualified sign language interpreters
Written information in other formats (large print, audio, accessible electronic formats, other formats)
Provides free language services to people whose primary language is not English, such as:
Qualified interpreters
Information written in other languages

If you need these services, contact Workplace Equity and Performance at wep@miami.edu or 305-284-3064.

If you believe that the University has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, by fax, or by email with:

University of Miami
Workplace Equity and Performance
1320 South Dixie Highway
Suite 355
Coral Gables, Florida 33146
Fax: 305-284-6211
Email: wep@miami.edu

If you need help filing a grievance, Workplace Equity and Performance is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–868–1019, 800–537–7697 (TDD). Complaint forms are available at hhs.gov/ocr/office/file/index.html.

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, contact Total Rewards at 305-284-3004. 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.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf or call 305-284-3004 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay
Are there services covered before you meet your deductible?	Yes, Preventive care only.	This plan covers some items and services even if you haven't yet met the deductible amount. However, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing with no deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	N/A	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?	Premium, balance-billed charges, 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.uhc.com or call 1-866-873-3903 for a list of network providers.	This plan uses a provider network. You must use a provider in the United Healthcare network. You will pay the most if you use an out-of-network provider as there are no out-of-network benefits. 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?	N/A	This plan only covers preventive care services.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

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
		In-network (You will pay the least)	Out-of-Network (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	Not Covered	Not Covered	
	Specialist visit	Not Covered	Not Covered	
	Preventive care/screening/ immunization	No Charge	Not Covered	You will have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Coverage for preventive care only
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com or by calling 1-855-438-4509	Generic drugs (Tier 1)	No Charge		Coverage for mandated over the counter drugs and women's contraceptives only.
	Preferred drugs (Tier 2)	Not Covered		
	Non-preferred brand drugs (Tier 3)	Not Covered		
	Specialty drugs (Tier 4)	Not Covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	
	Physician/surgeon fees	Not Covered	Not Covered	
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	
	Emergency medical transportation	Not Covered	Not Covered	
	Urgent care	Not Covered	Not Covered	

If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	
	Physician/surgeon fees	Not Covered	Not Covered	
If you need mental health, behavioral health, or substance	Outpatient services	Not Covered		
	Inpatient services	Not Covered		
If you are pregnant	Office visits	Not Covered	Not Covered	
	Childbirth/delivery professional services	Not Covered	Not Covered	
	Childbirth/delivery facility services	Not Covered	Not Covered	
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	
	Rehabilitation services	Not Covered	Not Covered	
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	Not Covered	Not Covered	
	Hospice services	Not Covered	Not Covered	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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)	• Chiropractic Care • Hearing Aids • Infertility treatments	• Long-term care • Non-emergency care when traveling outside the US • Private-duty nursing	• Routine eye care • 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.)

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/ebsa, or the U.S. Department of

Health and Human Services at 1-877-267-2323 x-61565 or www.cciio.cms.gov. 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: the Member Service number listed on the back of your ID card or www.myuhc.com. For plans subject to ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/ebsa.

Additionally, a consumer assistance program may help you file your appeal. Contact www.dol.gov/agencies/ebsa.

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? **No**
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 1-866-873-3903.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-873-3903.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-873-3903.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-873-3903.

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** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) copayment** **N/A**
- **Other coinsurance** **N/A**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,800
The total Peg would pay is	**$12,800**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) copayment** **N/A**
- **Other coinsurance** **N/A**

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*	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,400
The total Joe would pay is	**$7,400**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) copayment** **N/A**
- **Other coinsurance** **N/A**

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

Note: 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. 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 you aren't clear about any of the underlined terms used in this form see www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf for the glossary of terms.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-305-284-3064.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-305-284-3064.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-305-284-3064.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-305-284-3064.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-305-284-3064

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-305-284-3064.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-305-284-3064.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-305-284-3064.

x فـتا همصل امكبلوا: (مقر ة 1 - 305 - 284 - 3064ظوحلم: إذا تـنك ثـرك دحتت، اذةغللن اإف تـامدخ قدعاسملا اقيوغلل ارفاكلا وتت نلصت .اجملاب امقرب

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-305-284-3064.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-305-284-3064.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-305-2843064 번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-305-284-3064.

ચના : % ત ગuજરાતી બોલતા હો, તો િન:શuક ભાષા સહાય વાઓ તમારા મા= ઉપલ@ધ B. ફોન કરો 1-305-284-3064.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-305-284-3064.