



ADP TotalSource®

What You Need to Do



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Open Enrollment for the 2017–2018 Plan Year

Open Enrollment – when you'll update your benefits elections for the coming Plan Year – is here. Here's what you need to do.

ANSWER THIS QUESTION: Do I Need to Enroll?

Yes, you need to enroll if:

- You want to participate in a Health Care or Dependent Care Flexible Spending Account.
- You want to change benefits plans, or your current plan is no longer available.
- You are required to enroll under state insurance law (e.g., New York under certain conditions).

No, you don't need to enroll if:

- You don't want to participate in a Health Care or Dependent Care Flexible Spending Account.
- You want to keep your current benefits plans (at 2017–2018 rates) and they're still available.
- You only want to change your PCP or PCD (please contact your insurance carrier directly for this request).

If you need to enroll, follow these steps. If you are only eligible to enroll in an FSA, please skip to Step 2.

Don't Forget ...

If you want to participate in a Health Care or Dependent Care FSA, you must enroll in it each Plan Year.

Step 1. REVIEW	Step 2. CHOOSE	Step 3. TAKE ACTION
<p>You'll need to know what's changing and what your options are for the 2017–2018 Plan Year. Here are the key pages to review:</p> <ul style="list-style-type: none">■ Your Current Benefits – shows your current benefits elections.■ Plan Availability/Offering Changes – shows what plans (specific to you) are changing.	<p>You can enroll either by using the online Benefits Enrollment Wizard or by using the enclosed enrollment form.</p> <p>To Enroll Online:</p> <ul style="list-style-type: none">■ Read the enrollment instructions in this kit.■ Follow the step-by-step enrollment process on My TotalSource® at MyTotalSource.com. <p>To Enroll by Paper Form:</p> <ul style="list-style-type: none">■ Read the enrollment instructions in this kit.■ Complete the Health and Welfare Benefits Enrollment Form and return the form to: <p>ADP TotalSource ATTN: Benefits Center 10200 Sunset Drive Miami, FL 33173 Or fax to: (866) 616-8858</p>	<p>You must enroll online or submit your paper enrollment form before your enrollment deadline shown on the cover of this kit. If you don't enroll by the deadline, your new benefits elections won't be recorded or your new coverage may be delayed.</p> <p>If your current medical or dental plan is being replaced and you're being enrolled in an HMO, QPOS, POS/OA HMO or DMO replacement plan, you must elect a primary care physician (PCP) or primary care dentist (PCD) before your June 1 plan effective date by calling the insurance carrier directly. If you don't, your coverage may be interrupted, reducing your benefits. The phone number and website address for each insurance carrier appear on the plan's respective Summary of Benefits and Coverage in this kit.</p>

Health and Welfare Plan Open Enrollment 2017 - 2018

YOUR DEADLINE FOR ENROLLMENT IS 06/01/2017

Dear Worksite Employee:

Open Enrollment 2017 - 2018 for the ADP TotalSource, Inc. Health and Welfare Plan is here! The effective date for the new Plan Year is June 1, 2017. Open Enrollment is a time for you to review and compare your current coverage to that which is available for the new Plan Year to ensure that your coverage is aligned with you and your family's health care needs for the upcoming Plan Year. Additionally, if you are not currently participating, this is your opportunity to take advantage of the valuable benefits offered through the ADP TotalSource Health and Welfare Plan. Simply review your Open Enrollment Kit and make your elections. Please refer to the instruction pages that follow for more details on the process.

Important Information for the 2017 - 2018 Plan Year!

Health Care Reform Legislation

ADP TotalSource is committed to keeping you informed regarding Health Care Reform legislation. You will find a Health Care Reform flyer in this enrollment kit on specific provisions of the Affordable Care Act that are effective at this time for the ADP TotalSource, Inc. Health and Welfare Plan and may affect your benefit election choices for you and your family. Please refer to this informative flyer for the latest information on Health Care Reform provisions.

FSA Enrollment with New Debit Card and \$500 Carryover Features!

Please refer to the informational flyer in this kit for details on the Health Care FSA Debit Card and \$500 Health Care FSA carryover features. If you are currently enrolled in either the Health Care FSA or the Dependent Care FSA, **you must make a new election if you wish to enroll for the June 1, 2017 - May 31, 2018 Plan Year. Your current FSA elections will not be carried forward.** The maximum contribution limits for the 2017 - 2018 Plan year are \$2,600 for the Health Care FSA and \$5,000 (\$2,500, if married filing separately) for the Dependent Care FSA. Please be advised that if your employer does not offer group health coverage then a Health Care FSA will not be offered to you. Highly compensated employees will only be permitted to contribute up to \$2,000 per Plan Year to the Dependent Care FSA. Please note that participation by a Self-Employed Individual (SEI) in the Dependent Care FSA may be further limited by IRS guidelines. Please refer to the FSA benefit summaries in this kit for Plan details, the definition of a highly compensated employee, and SEI participation guidelines.

Please note that the claims filing deadline for FSA expenses incurred during the 2017 - 2018 Plan year is July 30, 2018.

Self-Employed Individuals

Please note if you are a Self-Employed Individual, there are certain tax rules and regulations which affect the taxable nature of the benefits which you may elect to receive through your employer and ADP TotalSource, Inc. Please refer to the Self-Employed Individual Benefit Participation Guide in the Benefits Quick Links section located on www.mytotalsource.com for further details.

Dependent Eligibility

The Health Care Reform Act requires group health plans and health insurance issuers to extend dependent coverage for adult children until age 26. Additionally, several states have passed legislation allowing parents to extend health coverage for their over age dependent children beyond age 26 that meet certain eligibility criteria. Please refer to the Dependent Eligibility Reference Guide in the Benefits Quick Links section located on www.mytotalsource.com for further details.

Tax Treatment of Non-Tax Dependents Benefits Coverage

If your enrolled dependent is not a tax dependent as defined by the Internal Revenue Code Section 152, you will be subject to federal and, if applicable, state income tax on the value of the coverage provided to such dependent(s). This value is considered "imputed income". TotalSource will determine the amount of imputed income periodically during the calendar year and will make adjustments to your taxable income as applicable. Please refer to the Employee Certification of Dependent Tax Status Form in this kit and the Non-Tax Dependent Imputed Income FAQ in the Benefits Quick Links section located on www.mytotalsource.com for further details.

Dependents' Social Security Numbers Required for Enrollment

The Centers for Medicare and Medicaid Studies (CMS) requires Social Security numbers (SSNs) for health plan subscribers and their dependents in order to comply with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. The Act establishes mandatory insurer reporting requirements, which help the CMS enforce Medicare secondary payer rules. In order to ensure compliance with these mandatory reporting requirements, our health insurance carriers require worksite employees to provide SSNs for all covered dependents. **As such, we will be unable to process the health plan enrollments for your identified dependents without the required SSN**

information. ADP TotalSource, as well as each of our health insurance carriers, takes strict precautions to ensure the security of your personal information, including your Social Security number. If you have questions about the security measures your health insurance carrier has in place, please call their Customer Service phone number before completing your enrollment elections.

Simply review your Enrollment Kit and make your elections. Please refer to the instruction pages that follow for more details on the process. If you do not have access to enroll online and are electing to make changes by completing the Health and Welfare Benefits Enrollment Form, please return the forms to the address or fax number indicated below.

ADP TotalSource
Attn: Benefits Center
10200 Sunset Drive
Miami, FL 33173
FAX: 1-866-616-8858

Thank you in advance for your cooperation.



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Action Section



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If you are making a benefit election for the 2017–2018 Plan Year, please enroll online or complete, sign and return all the forms in this section before your enrollment deadline. If you are waiving benefits, you must either enter your waiver online or complete the ADP TotalSource® Health and Welfare Enrollment Form in this section.



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Enrollment Instructions



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Plan Year 2017–2018

These instructions will help you quickly and easily enroll in your 2017–2018 Plan Year benefits. Enrolling online is the fastest way to choose your benefits. If you don't have internet access, see the next page for instructions on completing the paper enrollment form in this kit. Please be sure to enroll before the enrollment deadline.

Why Enroll Online?

The secure online Benefits Enrollment Wizard walks you through the process and helps you enroll quickly and correctly. It even includes a Learning Center with quick and helpful videos.

To Enroll Online:

Log in to My TotalSource® (MyTotalSource.com).

If you're logging in to My TotalSource for the first time, follow the instructions below:

1. Open a new browser window.
2. Copy the following URL, paste it into the address bar of your browser, and press the **Enter** key on your keyboard:
<https://totalsource.adp.com/ts/login.do>
3. Click the **SIGN UP** button. *If you've already registered, please skip to step 9.*
4. Enter your **registration code**. You can find your registration code on the upper right-hand side of the front page of this enrollment booklet.
5. Click the **NEXT** button.
6. Follow the online instructions and complete the registration.
7. Close the browser window.
8. Open a new browser window, copy the following URL, paste it into the address bar of your browser and press the **Enter** key on your keyboard: <https://totalsource.adp.com/ts/login.do>
9. Enter your user ID and password.
10. Click the **SIGN IN** button.

Once logged in to My TotalSource, view your current plan elections, costs and details by clicking **Myself** and then **My Benefits**.

Next, follow the step-by-step directions on the website to enroll.

1. Click **Myself** and then select **Benefit Enrollment**.
2. Click **Get Started** to access the Benefits Enrollment Wizard.
3. Follow the enrollment process and make your benefits selections.
4. After you've enrolled in or waived all coverage options, review your benefits elections carefully on the **Review and Submit Elections** page.
5. If your elections are correct, read and accept the Acknowledgements that appear at the bottom of the **Review and Submit Elections** page and choose **Submit**.

Congratulations – you're done!

For your records, print your benefits confirmation by clicking the **Print this Confirmation** link at the top of the **Confirmation** page. If applicable, click the temporary insurance card graphic to open and print your temporary card.

The benefits you elect will be effective through May 31, 2018 if you remain eligible. These cannot be changed until the next annual Open Enrollment period unless you experience an IRS-qualified change in status (see the Summary Plan Description for details). After you make your election, you will receive a confirmation statement summarizing your benefits elections.

Continues on next page.

To Enroll by Paper Form:

Follow the instructions below to complete the two-page Health and Welfare Benefits Enrollment Form in this kit. Incomplete forms will delay the processing of your benefits elections.

Important Note: If the health plan you elect requires a carrier-specific enrollment form to be completed, it will be included in this kit. Please return both enrollment forms to avoid enrollment delays.

To Waive/Cancel All Coverage(s):

If you're not enrolling in **any** of the benefits offered:

- Complete the **Personal Information** section or verify the pre-printed information for accuracy.
- Check () **Waive/Cancel All Coverage(s)** above the **Medical Options** section.
- Place a check () beside your reason for waiving coverage in the **Waive Medical Coverage** box.
- Complete the **Beneficiary Information** section (if life insurance is offered to you).
- Sign and date the enrollment form.

To Enroll in Benefits Coverage:

- Complete the **Personal Information** section or verify the pre-printed information for accuracy.
- **Medical Options** – Place a check () beside the plan and coverage level you want. If you don't want to enroll in a medical plan, place a check () beside your reason for waiving coverage in the **Waive Medical Coverage** box.
- **Dental & Vision Options** – Place a check () beside the plan and coverage level you want, or check () **Waive Coverage**.
- **Basic Life and AD&PL / Long-Term Disability / Short-Term Disability Plans** – If these benefits are offered to you, the level of coverage is indicated. You don't need to do anything.
- **FSA Options** – Write in the amount you want to contribute for the 2017–2018 Plan Year, or check () **Waive**.
- **Health Savings Account (HSA) Option*** – If you're currently contributing to the UMB HSA and if the HSA remains available to you, you can change the amount you contribute on the enrollment form.
- Complete the entire **General Information** section.

Dependent Information and PCP Designation** – All applicable fields in this section must be completed.

- If you're enrolling in an HMO, QPOS, POS/OA HMO or DMO plan, indicate for yourself and each covered dependent a primary care physician (PCP) or primary care dentist (PCD) by name and identification number.
- If you want dependent coverage under any benefit plans, you must provide each dependent's name, relationship to you, Social Security number, date of birth, and gender. Indicate with an "X" if they are to be enrolled in the medical, dental and/or vision plans (and provide PCP/PCD information, if applicable).
- ADP TotalSource® and our health insurance carriers require worksite employees to provide dependents' SSNs in order to comply with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.
- **Beneficiary Information** – Complete the table for each person you would like to designate as a beneficiary for basic life and AD&PL insurance, if applicable.
- **Authorization** – Sign and date the form at the bottom of page 2. If you reside in AZ, CA, ID, LA, NV, NM, TX, WA or WI, state law requires that your spouse also sign your enrollment form.

If you're enrolling in the HSA for the first time, you must log in to My TotalSource at MyTotalSource.com and click **Myself and then **Health Savings Account**. Once on the HSA page, you'll make your elections from the options presented.*

***It's very important that you write the date of birth, the Social Security number and the primary care physician's/dentist's name and identification number for each dependent to be covered, if applicable.*

Information about PCPs: If you're enrolling in an HMO, QPOS, POS/OA HMO or DMO plan, you must identify a primary care physician (PCP) or dentist (PCD) for you and each of your covered dependents by writing the provider's name and identification number (available in the plan's provider directory or on the plan's website) in the table. If you don't provide the PCP's or PCD's name and identification number, the carrier may assign a provider to you, or your plan identification cards will be delayed.

Health and Welfare Benefits Enrollment Form (2017-2018 Plan Year)

Personal Information

Name: _____
 Address: _____
 Phone #: () _____

SSN: _____ - - -
 Gender: M / F
 Date of Birth: / /
 Date of Hire: / /

Medical, Dental and Vision premiums listed reflect the employee's monthly premium responsibility by coverage level.

Waive/Cancel All Coverage(s). (Medical option waiver section must be completed)

Medical Options- Elect one (1) Medical plan or Waive coverage

Plan Offering(s)	Plan Codes(s)	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
UHC-CP-AHIE-3000-OH-FL	BCHN1	() \$ 84.00	() \$ 577.50	() \$ 538.00	() \$ 836.00
UHC-CP-AHLR-1000-80-OH-FL	BCHD1	() \$ 154.00	() \$ 651.50	() \$ 607.50	() \$ 944.00
UHC-CP-AHLU-1500-OH-FL	BCHG1	() \$ 224.00	() \$ 727.00	() \$ 677.50	() \$ 1,053.00
UHC-CP-AHLV-2000-OH-FL	BCHJ1	() \$ 160.00	() \$ 658.00	() \$ 614.00	() \$ 953.50

Dental Options - Elect one (1) Dental plan or Waive coverage

Plan Offering(s)	Plan Codes(s)	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Guardian-Value Midwest	ACOU1	() \$ 27.07	() \$ 54.17	() \$ 56.74	() \$ 86.92

Vision Options - Elect or Waive Vision coverage

Plan Offering(s)	Plan Codes(s)	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
VSP- Choice Vision Plan	ASCX1	() \$ 6.46	() \$ 12.93	() \$ 13.84	() \$ 22.12

Life and Disability Plan Options

Plan Type	Plan Offering(s)	Plan Eligibility
Life LTD	Basic \$10,000 LTD Basic 50% \$1,000/mo-180	Life offered only to those who elect medical benefits LTD offered only to those who elect medical benefits

Flexible Spending Account (FSA) Plan Options

	Minimum Contribution	Maximum Contribution	Plan Year Election
() I wish to enroll in the Health Care Flexible Spending Account	\$50	\$2,600.00	\$_____
() I wish to enroll in the Dependent Care Flexible Spending Account	\$50	\$5,000.00 (\$2,500 if married filing separately)	\$_____

IMPORTANT: This form has multiple pages. All pages must be completed (including your signature on the last page) and submitted, or your benefit elections may be delayed.

Waive Medical Coverage

- () I certify that I am declining medical coverage at this time because I am currently covered under another health plan.
 () I certify that I am declining medical coverage at this time and I am NOT currently covered under another health plan

Waive Dental Coverage

- () Waive Coverage

Waive Vision Coverage

- () Waive Coverage

Waive Flexible Spending Account Coverage

- () Waive Health Care FSA Coverage
 () Waive Dependent Care FSA Coverage

Company: Family Entertainment Group, LL
 Paygroup: 8SI / 739170
 Region: Mid-West
 HRG: Amy Mieding
 Ben Rep: Specialists Central Benefits
 ~~~~~~  
 Class Code: A / All Employees  
 Class State: OH  
 Waiting Pd: 30 Days



Enrollment Deadline is 06/01/2017

Effective Date: 06/01/2017

# Health and Welfare Benefits Enrollment Form (2017-2018 Plan Year)

Enrollment Deadline is 06/01/2017

Effective Date: 06/01/2017

Company: Family Entertainment Group, LL

Paygroup: 8SI / 739170 / Mid-West

## DEPENDENT INFORMATION AND PCP DESIGNATION

In this section, list yourself and all of your eligible dependents whom you wish to cover under a benefit plan. Provide complete information for each dependent, and identify the benefit plan(s) in which you wish to enroll each dependent by marking "X" under the appropriate benefit plan option(s).

| Name | Relation | SS# | Date of Birth | Gender | Election Information |            |        |
|------|----------|-----|---------------|--------|----------------------|------------|--------|
|      |          |     |               |        | Medical PCP          | Dental PCD | Vision |
|      | Employee |     |               |        |                      |            |        |
|      |          |     |               |        |                      |            |        |
|      |          |     |               |        |                      |            |        |
|      |          |     |               |        |                      |            |        |
|      |          |     |               |        |                      |            |        |
|      |          |     |               |        |                      |            |        |

## BENEFICIARY INFORMATION (List individual(s) you wish to designate as Basic Life Insurance beneficiaries)

| Name | Relation | SS# | Date of Birth | Address | Amt. or % | Primary or Contingent | Basic Life |
|------|----------|-----|---------------|---------|-----------|-----------------------|------------|
|      |          |     |               |         |           |                       |            |
|      |          |     |               |         |           |                       |            |
|      |          |     |               |         |           |                       |            |
|      |          |     |               |         |           |                       |            |

## AUTHORIZATION

I have read the explanation of my Health and Welfare benefits options for the current Plan Year. I authorize the elections I have made, as well as any pre-tax payroll deductions required for these elections unless I complete an additional form requesting that benefit deductions be taken on a post-tax basis. I understand that during this or any future open enrollments if I do not make changes to my then-current health plan elections, my elections will default to either the same health plan election or a designated replacement health plan election specified in the personal statement for that enrollment period, and that such a default may result in a higher cost and increased deduction from my pay. By signing this Form, I am also authorizing any pre-tax deductions required to cover the defaulting elections.

I understand that if I am considered a Self-Employed Individual, according to the Internal Revenue Code, I am not eligible to pay for my benefits under the ADP Total Source Health and Welfare Plan ("Plan") on a pre-tax basis, and I am not eligible to make contributions to the Health Care FSA. I may make post-tax contributions to the Dependent Care FSA if I am otherwise receiving wages that are reportable on a Form W-2.\* I acknowledge that in the event of the termination of my employment, my health, dental, vision and group life insurance coverage will continue through the end of the month in which my termination occurs. Other coverage, such as disability and participation in the FSA plan (if applicable), will end on the date of my employment termination. I agree that upon my termination, the amount needed to cover my contributions to my insurance premium(s) for that month's coverage becomes immediately due and payable and will be deducted from my final paycheck(s). I understand that this final deduction amount may be higher than the amounts deducted in previous pay periods. I understand that I cannot change my elections before the next annual enrollment period, unless a qualified change in status occurs and my requested election change is consistent with the change in status event\* I understand that if I am a newly-eligible employee waiving medical coverage because I am covered under another medical plan, I must indicate this under the medical options section by choosing the first "Waive Coverage" option. Absence of this indication may affect my eligibility for HIPAA special enrollment period should I lose this other coverage at a later date.\*

I hereby certify that the above information is complete and accurate.

Worksite Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

Required only for married residents of AZ, CA, ID, LA, NV, NM, TX, WA and WI who are designating a non-spouse beneficiary for the life insurance option.

\*Please see the ADP TotalSource, Inc. Health and Welfare Plan Summary Plan Description for further details.



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## Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)



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If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, 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, contact your state Medicaid or CHIP office, dial **1-877-KIDS NOW**, or visit [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you **must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your state for more information on eligibility.**

### ALABAMA – Medicaid

Website: <http://myalhipp.com/>

Phone: 1-855-692-5447

### FLORIDA – Medicaid

Website: <http://flmedicaidtplrecovery.com/hipp/>

Phone: 1-877-357-3268

### ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: <http://myakhipp.com/>

Phone: 1-866-251-4861

Email: [CustomerService@MyAKHIPP.com](mailto:CustomerService@MyAKHIPP.com)

Medicaid Eligibility:

<http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

### GEORGIA – Medicaid

Website: <http://dch.georgia.gov/medicaid>

— Click on Health Insurance Premium Payment (HIPP)

Phone: 404-656-4507

### ARKANSAS – Medicaid

Website: <http://myarhipp.com/>

Phone: 1-855-MyARHIPP (855-692-7447)

### INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19–64

Website: <http://www.hip.in.gov>

Phone: 1-877-438-4479

All other Medicaid

Website: <http://www.indianamedicaid.com>

Phone 1-800-403-0864

|                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>COLORADO – Medicaid</b>                                                                                                                                                                    | <b>IOWA – Medicaid</b>                                                                                                                                                                                                                                                                                                                  |
| Medicaid Website: <a href="http://www.colorado.gov/hcpf">http://www.colorado.gov/hcpf</a><br>Medicaid Customer Contact Center: 1-800-221-3943                                                 | Website: <a href="http://www.dhs.state.ia.us/hipp/">http://www.dhs.state.ia.us/hipp/</a><br>Phone: 1-888-346-9562                                                                                                                                                                                                                       |
| <b>KANSAS – Medicaid</b>                                                                                                                                                                      | <b>NEW HAMPSHIRE – Medicaid</b>                                                                                                                                                                                                                                                                                                         |
| Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a><br>Phone: 1-785-296-3512                                                                                         | Website: <a href="http://www.dhhs.nh.gov/oi/documents/hippapp.pdf">http://www.dhhs.nh.gov/oi/documents/hippapp.pdf</a><br>Phone: 603-271-5218                                                                                                                                                                                           |
| <b>KENTUCKY – Medicaid</b>                                                                                                                                                                    | <b>NEW JERSEY – Medicaid and CHIP</b>                                                                                                                                                                                                                                                                                                   |
| Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a><br>Phone: 1-800-635-2570                                                                         | Medicaid Website:<br><a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a><br>Medicaid Phone: 609-631-2392<br>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a><br>CHIP Phone: 1-800-701-0710 |
| <b>LOUISIANA – Medicaid</b>                                                                                                                                                                   | <b>NEW YORK – Medicaid</b>                                                                                                                                                                                                                                                                                                              |
| Website: <a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a><br>Phone: 1-888-695-2447                                         | Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a><br>Phone: 1-800-541-2831                                                                                                                                                                                             |
| <b>MAINE – Medicaid</b>                                                                                                                                                                       | <b>NORTH CAROLINA – Medicaid</b>                                                                                                                                                                                                                                                                                                        |
| Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a><br>Phone: 1-800-442-6003<br>TTY: Maine relay 711 | Website: <a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a><br>Phone: 919-855-4100                                                                                                                                                                                                                                       |
| <b>MASSACHUSETTS – Medicaid and CHIP</b>                                                                                                                                                      | <b>NORTH DAKOTA – Medicaid</b>                                                                                                                                                                                                                                                                                                          |
| Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a><br>Phone: 1-800-462-1120                                                                                 | Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a><br>Phone: 1-844-854-4825                                                                                                                                                                               |
| <b>MINNESOTA – Medicaid</b>                                                                                                                                                                   | <b>OKLAHOMA – Medicaid and CHIP</b>                                                                                                                                                                                                                                                                                                     |
| Website: <a href="http://mn.gov/dhs/ma/">http://mn.gov/dhs/ma/</a><br>Phone: 1-800-657-3739                                                                                                   | Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a><br>Phone: 1-888-365-3742                                                                                                                                                                                                                             |
| <b>MISSOURI – Medicaid</b>                                                                                                                                                                    | <b>OREGON – Medicaid</b>                                                                                                                                                                                                                                                                                                                |
| Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a><br>Phone: 573-751-2005                                     | Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a><br><a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a><br>Phone: 1-800-699-9075                                                                                |
| <b>MONTANA – Medicaid</b>                                                                                                                                                                     | <b>PENNSYLVANIA – Medicaid</b>                                                                                                                                                                                                                                                                                                          |
| Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a><br>Phone: 1-800-694-3084                                         | Website: <a href="http://www.dhs.pa.gov/hipp">http://www.dhs.pa.gov/hipp</a><br>Phone: 1-800-692-7462                                                                                                                                                                                                                                   |

|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>NEBRASKA – Medicaid</b>                                                                                                                                                                                                                                                                                                                                       | <b>RHODE ISLAND – Medicaid</b>                                                                                                                                                                                                                                  |
| Website: <a href="http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx</a><br>Phone: 1-855-632-7633                                                                                                                            | Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a><br>Phone: 401-462-5300                                                                                                                                                                 |
| <b>NEVADA – Medicaid</b>                                                                                                                                                                                                                                                                                                                                         | <b>SOUTH CAROLINA – Medicaid</b>                                                                                                                                                                                                                                |
| Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a><br>Medicaid Phone: 1-800-992-0900                                                                                                                                                                                                                                                        | Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a><br>Phone: 1-888-549-0820                                                                                                                                                                     |
| <b>SOUTH DAKOTA - Medicaid</b>                                                                                                                                                                                                                                                                                                                                   | <b>WASHINGTON – Medicaid</b>                                                                                                                                                                                                                                    |
| Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a><br>Phone: 1-888-828-0059                                                                                                                                                                                                                                                                              | Website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a><br>Phone: 1-800-562-3022, ext. 15473 |
| <b>TEXAS – Medicaid</b>                                                                                                                                                                                                                                                                                                                                          | <b>WEST VIRGINIA – Medicaid</b>                                                                                                                                                                                                                                 |
| Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a><br>Phone: 1-800-440-0493                                                                                                                                                                                                                                                                | Website: <a href="http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx">http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx</a><br>Phone: 1-877-598-5820, HMS Third Party Liability                                                |
| <b>UTAH – Medicaid and CHIP</b>                                                                                                                                                                                                                                                                                                                                  | <b>WISCONSIN – Medicaid and CHIP</b>                                                                                                                                                                                                                            |
| Website:<br>Medicaid: <a href="http://health.utah.gov/medicaid">http://health.utah.gov/medicaid</a><br>CHIP: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a><br>Phone: 1-877-543-7669                                                                                                                                                      | Website:<br><a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a><br>Phone: 1-800-362-3002                                                                                            |
| <b>VERMONT– Medicaid</b>                                                                                                                                                                                                                                                                                                                                         | <b>WYOMING – Medicaid</b>                                                                                                                                                                                                                                       |
| Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a><br>Phone: 1-800-250-8427                                                                                                                                                                                                                                              | Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a><br>Phone: 307-777-7531                                                                                                                                           |
| <b>VIRGINIA – Medicaid and CHIP</b>                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                 |
| Medicaid Website:<br><a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a><br>Medicaid Phone: 1-800-432-5924<br>CHIP Website:<br><a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a><br>CHIP Phone: 1-855-242-8282 |                                                                                                                                                                                                                                                                 |

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

## **Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email <mailto:mebsa.opr@dol.gov> and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)



## Voluntary Benefits

During Open Enrollment, you may also have the opportunity to sign up for select TotalChoice<sup>TM</sup> Voluntary Benefits available through ADP TotalSource's partnership with Mercer.

**Depending on your eligibility, the following voluntary benefits may be elected during the enrollment window without proof of good health:**



Critical Illness



Accident



Hospital Indemnity Insurance



Term Life Insurance  
(up to \$100,000)

Additionally, eligible employees can elect short-term disability (up to 60% benefit coverage level) with evidence of insurability completion (medical questionnaire) or group legal services coverage.

To enroll in these benefits, log in to **My TotalSource<sup>®</sup>** and click **Myself > Benefits Resource Center > TotalChoice Voluntary Benefits.**

**To learn what these benefits are and how they can help complete your benefits packages, visit [MyLife@MyTotalSource](mailto:MyLife@MyTotalSource) ([mylife.adpts.com](http://mylife.adpts.com)).**

<sup>1</sup>Agency for Healthcare Research and Quality, Mean Expenses per Person with Care for Selected Conditions by Type of Service: United States, 2012, Medical Expenditure Panel Survey Household Component Data. Generated interactively.

<sup>2</sup>Coverage is guaranteed provided (1) you are actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.

METLIFE'S ACCIDENT AND HOSPITAL INDEMNITY INSURANCE POLICIES ARE LIMITED BENEFIT GROUP INSURANCE POLICIES. The policy is not intended to be a substitute for medical coverage and certain states may require the insured to have medical coverage to enroll for the coverage. The policies or their provisions may vary or be unavailable in some states. There is a preexisting condition exclusion for hospital sickness benefits, if applicable. There are benefit reductions that begin at age 65. And, like most group accident and health insurance policies, policies offered by MetLife may contain certain exclusions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP12-AX or GPNP12-HI or contact MetLife. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York. In certain states, availability of MetLife's Group Accident and Hospital Indemnity Insurance are pending regulatory approval. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details. METLIFE'S CRITICAL ILLNESS INSURANCE (CI) IS A LIMITED BENEFIT GROUP INSURANCE POLICY. Like most group accident and health insurance policies, MetLife's CI policies contain certain exclusions, limitations and terms for keeping them in force. Product features and availability vary by state. There is a preexisting condition exclusion. There is a Benefit Suspension Period between Recurrences. Attained Age rates are based on 5-year age bands and will increase when a Covered Person reaches a new age band. Rates are subject to change. A more detailed description of the benefits, limitations, and exclusions can be found in the applicable Disclosure Statement or Outline of Coverage/Disclosure Document available at time of enrollment. For complete details of coverage and availability, please refer to the group policy form GPNP07-CI or GPNP10-CI, or contact MetLife for more information. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York. Like most group accident and health insurance plans, these plans contain certain exclusions and limitations. Please review the plan summaries on the Mercer Marketplace and see the MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

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Program Offered and Administered by Mercer Health & Benefits Administration LLC

In CA d/b/a Mercer Health & Benefits Insurance Services LLC AR Ins. Lic. #100102691 CA Ins. Lic. #0G39709

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ADP TotalSource®

## Employee Certification of Dependent Tax Status



**Instructions:** Complete and return this form only if you're enrolling one or more dependents in the following categories for benefits coverage:

- Adult children who have reached age 26
- Civil union partners and their children

### Certification of Tax Dependent

I understand that the following rules apply to the federal income tax treatment of benefits coverage:

If my above-mentioned dependent is not a tax dependent as defined below, I will be subject to federal and, if applicable, state income tax on the value of the coverage provided to my dependent. The taxable value of the coverage is considered imputed income, and the amount of imputed income will be determined by ADP TotalSource® periodically during the calendar year. ADP TotalSource will make this adjustment on periodic payrolls during the calendar year, and I'll be notified prior to any payroll adjustments. I understand that this adjustment may increase my federal and, if applicable, state income tax liability.

#### For an adult child who has reached age 26:

- Federal and, if applicable, state tax will apply to any coverage provided to an adult child beginning January 1 of the calendar year in which the adult child will attain age 27, unless the adult child qualifies as a tax dependent due to being permanently and totally disabled, as described in Code Section 152(c).

#### For civil union partners:

- You provide more than half of your civil union partner's total support for the calendar year;
- You and your civil union partner have the same principal place of abode for the entire calendar year, except for temporary reasons such as vacation, military service or education;
- Your civil union partner is a member of your household for the entire calendar year (and the relationship doesn't violate local law);
- Your civil union partner isn't your (or anyone else's) "qualifying child" under Code Section 152(c);
- Your civil union partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada or Mexico; and
- Your civil union partner's gross income for the year is less than \$4,050.

#### For a civil union partner's child who isn't also your child:

- Your civil union partner's child who isn't also your child (a "covered child") may qualify as your tax dependent for health coverage purposes if they satisfy the above test or if they satisfy the "qualifying child" test found in Code Section 152(c).

Please consult with your tax advisor before certifying below whether your enrolled dependent is a tax dependent as defined by the Internal Revenue Code for health coverage purposes. Also list any dependent(s) you're enrolling from the above-listed dependent categories and indicate their tax status.

| Last Name | First Name | Dependent Relationship | Dependent Tax Status                   |                                              |
|-----------|------------|------------------------|----------------------------------------|----------------------------------------------|
|           |            |                        | <input type="checkbox"/> Tax Dependent | <input type="checkbox"/> Not a Tax Dependent |
|           |            |                        | <input type="checkbox"/> Tax Dependent | <input type="checkbox"/> Not a Tax Dependent |
|           |            |                        | <input type="checkbox"/> Tax Dependent | <input type="checkbox"/> Not a Tax Dependent |
|           |            |                        | <input type="checkbox"/> Tax Dependent | <input type="checkbox"/> Not a Tax Dependent |

I certify the tax status of my dependent(s) listed above as defined by the Internal Revenue Code. I understand that ADP TotalSource will rely on this certification to determine my federal and, if applicable, state income and employment taxes. I further understand that I must notify ADP TotalSource if conditions change that would cause my dependent(s) to no longer qualify as my tax dependent(s).

---

Employee Name

Last 4 Digits of SSN or Employee ID

---

Employee Signature

Date

**EMAIL, FAX OR MAIL COMPLETED FORM TO:**

ADP TotalSource  
Attention: Benefits Center  
10200 Sunset Drive  
Miami, FL 33173  
**Fax:** (866) 616-8858  
**Email:** Status\_Change@adp.com



ADP TotalSource®

# Reference Section



A more human resource.<sup>SM</sup>

**The contents of this section are for review only.**  
**Nothing in this section needs to be returned.**

**SUMMARY OF MATERIAL MODIFICATIONS  
TO THE SUMMARY PLAN DESCRIPTION FOR THE ADP TOTALSOURCE, INC.  
HEALTH AND WELFARE PLAN**

Note: This document contains important information concerning your benefits. Please review this information carefully and retain with your benefit materials for future reference. Please note that eligibility varies by benefit option and your worksite employer's elections. Those benefit options you are entitled to are described in your benefits enrollment kit.

You previously received enrollment information for the Health and Welfare Plan ("Plan"). This document is a Summary of Material Modifications ("SMM") for the 2014-2015, 2015-2016, 2016-2017 and 2017-2018 Plan years for your review and records, and it contains changes to the Summary Plan Description ("SPD") that you previously received. You may obtain a copy of the SPD by logging on to My TotalSource at [www.mytotalsource.com](http://www.mytotalsource.com) or calling the Employee Service Center at 1-800-554-1802 or by email at [esc@adp.com](mailto:esc@adp.com).

This SMM is intended to summarize the Plan amendments. If there is a conflict between this SMM and the actual language of the Plan, the Plan language controls.

**Summaries of the Plan Modifications are as follows:**

**EFFECTIVE JUNE 1, 2014**

**Addition of Health Care Flexible Spending Account (FSA) Carry Over Provision**

For the 2014-2015 Plan Year and each Plan Year thereafter, participants in the Health Care FSA are permitted to carry over up to \$500 of their remaining account balance as of the current Plan Year claim filing deadline. Eligible carryover amounts will be applied to the following Plan Year. The carryover of up to \$500 does not affect the maximum amount that a participant can elect to contribute in the new Plan Year.

**EFFECTIVE JANUARY 1, 2015**

**Change to High-Deductible Health Plan (HDHP) Annual Deductible and Out-of-Pocket Maximum for 2015**

On page 16 of the Summary Plan Description under the section titled **HDHP Annual Deductible and Out-of-Pocket Maximum**, the 2015 Calendar Year requirements are added as follows:

2015 Calendar Year limits are as follows:

**2015 Annual HDHP Minimum Deductibles:**

Self-only coverage: \$1,300

Family coverage: \$2,600

**2015 HDHP Maximum Out-of-Pocket Limits:** (includes deductibles, copayments and co-insurance, but not premiums)

Self-only coverage: \$6,450

Family coverage: \$12,900

**Change to Health Savings Account Contribution (HSA) Limits for 2015**

On page 33 of the Summary Plan Description under the section titled **Contribution Limits**, the stated HSA contribution limits are changed effective January 1, 2015 as follows:

- Contribution limit for individual coverage in 2015 is \$3,350.
- Contribution limit for family coverage in 2015 is \$6,650.

An individual who has reached the age of 55 by the end of the calendar year may contribute an additional \$1,000 per year. These maximums are subject to change by the IRS each January 1<sup>st</sup>.

### Change to Flexible Spending Account (FSA) Online Access

On page 25 of the Summary Plan Description under the section titled **Requesting Reimbursement**, the first sentence of the 3<sup>rd</sup> paragraph is changed to read:

"You can submit an online reimbursement request and access claim forms and further details on how to submit claims by logging in to My TotalSource at mytotalsource.com and clicking **Myself**, then the **Spending Accounts** menu option. This will take you directly to the ADP secure website at myspendingaccount.adp.com and will not require that you register for access. Please note that if you log in to the myspendingaccount.adp.com website directly, you'll need to register on the website to create your login for online access to your spending account(s). Once on the website, click Register for online access.

On page 25, in the call-out box titled **New Health Care FSA Spending Account Card**, the last sentence is changed to read: "Learn more at myspendingaccount.adp.com."

On pages 28 and 30, the sections titled **Managing Your FSA**, are changed to read:

"The best place for you to find all the information you need to manage your FSA is at myspendingaccount.adp.com, which can be accessed directly through My TotalSource by selecting **Myself** and then the **Spending Accounts** menu option. Alternatively, you can call the toll-free ADP TotalSource Employee Service Center at 800-554-1802 to be transferred to the FSA participant hotline. The hotline is staffed Monday through Friday from 8 a.m. to 8 p.m. ET."

### Change to Facts About the Plan - Trustees

On page 64 of the Summary Plan Description, the section titled **Trustees of the ADP TotalSource, Inc. Health and Welfare Plan Trust** is changed as follows:

Maria Black, President, ADP TotalSource  
Cristian Orihuela, VP, Health and Wealth

Mark Acquadro, Vice President - Finance

## **EFFECTIVE JUNE 1, 2015**

### Change to Health Care Flexible Spending Account (FSA) Contribution Limits

On page 28 of the Summary Plan Description under the section titled **Contribution Limits**, the stated Health Care FSA contribution limits are changed effective June 1, 2015 to \$2,550 per Plan Year.

### Change to Definition of Highly Compensated Employee for the 2015-2016 and 2016-2017 Plan Years

On page 30 of the Summary Plan Description under the section titled **Contribution Limits for Highly Compensated Employees**, the following definition is added:

**"For the 2015-2016 and 2016-2017 Plan Years**, a "highly compensated employee" is defined by the IRS as an individual that (a) owns (or constructively owns) more than 5% of the stock, capital or profits interest of a Client Company on any day during the Plan Year, or (b) will be paid compensation by ADP TotalSource in excess of **\$120,000** annually. The definition of a highly compensated employee may change for future Plan Years."

### Update Regarding Health Savings Account (HSA) Participation when Qualifying for a Health FSA Carryover

On page 35 of the Summary Plan Description, the following is added to the end of the response to the question, **Can I have a Flexible Spending Account (FSA) if I have an HSA?** "Also, if you have a Health Care FSA carryover from the prior Plan Year, your Health Care FSA carryover will be converted to a Limited FSA carryover due to IRS rules."

## **EFFECTIVE JANUARY 1, 2016**

### **Change to High-Deductible Health Plan (HDHP) Annual Deductible and Out-of-Pocket Maximum for 2016**

On page 16 of the Summary Plan Description under the section titled **HDHP Annual Deductible and Out-of-Pocket Maximum**, the 2016 Calendar Year requirements are added as follows:

2016 Calendar Year limits are as follows:

#### **2016 Annual HDHP Minimum Deductibles:**

Self-only coverage: \$1,300  
Family coverage: \$2,600

#### **2016 HDHP Maximum Out-of-Pocket Limits:** (includes deductibles, copayments and co-insurance, but not premiums)

Self-only coverage: \$6,550  
Family coverage: \$13,100

### **Change to Health Savings Account Contribution (HSA) Limits for 2016**

On page 33 of the Summary Plan Description under the section titled **Contribution Limits**, the stated HSA contribution limits are changed effective January 1, 2016 as follows:

- Contribution limit for individual coverage in 2016 is \$3,350.
- Contribution limit for family coverage in 2016 is \$6,750.

An individual who has reached the age of 55 by the end of the calendar year may contribute an additional \$1,000 per year. These maximums are subject to change by the IRS each January 1<sup>st</sup>.

### **Change to Health Savings Account Eligibility**

On page 32 of the Summary Plan Description under the section titled **ELIGIBILITY**, a bullet is added to read:

"Note: Coverage under a non-qualified high-deductible health plan (as a primary insured or as a dependent) will make you ineligible for participation in a Health Savings Account. Non-qualified plans include (but not limited to) Medicare, Medicaid, and Tri-Care."

### **Change to Imputed Income – Group Term Life**

On page 40 of the Summary Plan Description under the section titled **IMPUTED INCOME Group Term Life**, the **Note** is changed to read as follows:

"The **full** value of any employer-provided group term life insurance coverage will be considered taxable income for 2% S-Corp Owners and Members of an LLC that is taxed as an S-Corp. Any taxable group term life coverage provided to you in excess of \$50,000 will be included in your income on your paycheck and will be subject to all applicable withholding taxes, however, the imputed income on the value of coverage up to \$50,000 will be applied once a year in December."

### **Change to Employee Assistance Program (EAP)**

On page 54 of the Summary Plan Description, under the Employee Assistance Program, the second sentence of the second paragraph is changed to read as follows:

"You and each of your qualified dependents may see the licensed professional up to three sessions per episode, to a maximum of three episodes at no charge. There is a maximum of nine sessions, per person, per calendar year."

## EFFECTIVE JANUARY 1, 2017

### Change to Eligibility – New Hires and New Clients

On page 10 of the Summary Plan Description under the section titled **New Hires and Waiting Period**, and the section titled **New Clients**, the first bullet is changed to read as follows:

- “you are a regular full-time or part-time employee of an ADP TotalSource worksite employer residing or working in the United States, scheduled to work an average of 30 hours per week; and”

### Change to High-Deductible Health Plan (HDHP) Annual Deductible and Out-of-Pocket Maximum for 2017

On page 16 of the Summary Plan Description under the section titled **HDHP Annual Deductible and Out-of-Pocket Maximum**, the 2017 Calendar Year requirements are added as follows:

2017 Calendar Year limits are as follows:

#### 2017 Annual HDHP Minimum Deductibles:

Self-only coverage: \$1,300  
Family coverage: \$2,600

#### 2017 HDHP Maximum Out-of-Pocket Limits: (includes deductibles, copayments and co-insurance, but not premiums)

Self-only coverage: \$6,550  
Family coverage: \$13,100

### Change to Health Savings Account Contribution (HSA) Limits for 2017

On page 33 of the Summary Plan Description under the section titled **Contribution Limits**, the stated HSA contribution limits are changed effective January 1, 2017 as follows:

- Contribution limit for individual coverage in 2017 is \$3,400.
- Contribution limit for family coverage in 2017 is \$6,750.

An individual who has reached the age of 55 by the end of the calendar year may contribute an additional \$1,000 per year. These maximums are subject to change by the IRS each January 1<sup>st</sup>.

### Change to Facts About the Plan – Trustees and Benefits Committee

On page 64 of the Summary Plan Description, the section titled **Trustees of the ADP TotalSource, Inc. Health and Welfare Plan Trust** is changed as follows:

The Trustees include:

Mark Acquadro, Vice President – Finance  
Pawan Chhabra, Chief Financial Officer

## EFFECTIVE JUNE 1, 2017

### Change to Health Care Flexible Spending Account (FSA) Contribution Limits

On page 28 of the Summary Plan Description under the section titled **Contribution Limits**, the stated Health Care FSA contribution limits are changed effective June 1, 2017 to \$2,600 per Plan Year.

## **IMPORTANT ANNUAL BENEFIT NOTICE(S)**

### **Annual Notice Regarding the Women's Health and Cancer Rights Act**

**This law requires plans that provide medical and surgical benefits for mastectomies to provide coverage for the following procedures, as requested from the patient in consultation with her physician:**

- **Reconstruction of the breast on which the mastectomy has been performed;**
- **Surgery and reconstruction of the other breast to produce a symmetrical appearance;**
- **Prosthesis (e.g., breast implant); and**
- **Treatment for physical complications of all stages of the mastectomy, including lymphedemas.**

### **HIPAA Notice of Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 60 days after your other coverage ends. In addition, 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 60 days after the marriage, birth, adoption, or placement for adoption.

Also, under the Children's Health Insurance Program Reauthorization Act you or your dependent that is eligible, but not enrolled in the Plan, may enroll if either of the following two conditions are met:

- (1) You or your dependent are covered under a Medicaid plan or under a State child health plan and the coverage is terminated due to loss of eligibility and you request coverage under the Plan no later than 60 days after the loss of eligibility; or
- (2) Your or your dependent become eligible for assistance for coverage under the Plan, Medicaid plan or State child health plan and you request coverage under the Plan no later than 60 days after you or your dependent are determined to be eligible for assistance.

### **PATIENT PROTECTION - PRIMARY CARE PHYSICIAN (PCP) AND OB/GYN SELECTION**

Many of the ADP TotalSource health plans require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the health plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the ADP TotalSource health insurance carriers or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health insurance carrier at the phone number indicated on the Benefit Summary provided in your benefits enrollment kit.

**!** 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](http://www.welcometouhc.com) or by calling 1-800-782-3740. 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](http://www.cciio.cms.gov) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-866-487-2365 to request a copy.

| Important Questions                                                | Answers                                                                                                                                          | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <u>What is the overall deductible?</u>                             | Network: \$3,000 Individual / \$6,000 Family<br>Non-Network: \$5,000 Individual / \$10,000 Family<br>Per calendar year.                          | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have <u>other family members</u> on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.                                                                                      |
| <u>Are there services covered before you meet your deductible?</u> | Yes. Preventive care and categories with a <u>copay</u> are covered before you meet your deductible.                                             | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <u>Are there other deductibles for specific services?</u>          | No.                                                                                                                                              | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <u>What is the out-of-pocket limit for this plan?</u>              | Network: \$6,000 Individual / \$12,000 Family<br>Non-Network: \$6,250 Individual / \$12,500 Family                                               | The out-of-pocket limit is the most you could pay in a year for covered services. If you have <u>other family members</u> in this <u>plan</u> , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.                                                                                                                                                                                                                         |
| <u>What is not included in the out-of-pocket limit?</u>            | Premiums, <u>balance-billing</u> charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.                                                                                                                                                                                                                                                                                                                                                                                         |
| <u>Will you pay less if you use a network provider?</u>            | Yes. See <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> or call 1-800-782-3740 for a list of <u>network providers</u> .          | This <u>plan</u> uses a <u>provider network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.     |
| <u>Do you need a referral to see a specialist?</u>                 | No.                                                                                                                                              | You can see the specialist you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                   |



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                               | Non-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                 |
|--------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 | 20% coinsurance                              | Virtual visits (Telehealth) - \$25 copay per visit by a Designated Virtual Network Provider, deductible does not apply.<br>If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery. |
|                                                        | Specialist visit                                                    | \$50 copay per visit, deductible does not apply | 20% coinsurance                              | If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.                                                                                                                            |
| Preventive care/screening/immunization                 |                                                                     | No Charge                                       | 20% 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)<br>Imaging (CT/PET scans, MRIs) | No Charge<br>0% coinsurance                     | 20% coinsurance<br>20% coinsurance           | Preauthorization required for non-network for certain services or benefit reduces to 50% of allowed.<br>Preauthorization required for non-network or benefit reduces to 50% of allowed.                                                                |

| 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 | Tier 1 - Generic drugs - Your Lowest-Cost Option<br><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> . | Deductible does not apply. Retail:<br>\$15 <u>copay</u><br>Mail-Order:<br>\$37.50 <u>copay</u><br>Specialty Drugs:<br>\$15 <u>copay</u>   | Deductible does not apply. Retail:<br>\$15 <u>copay</u>                                        | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 31 day supply.<br>Mail-Order: Up to a 90 day supply.<br>If you use a non-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.<br><u>Copay</u> is per prescription order up to the day supply limit listed above.<br>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.<br>Certain drugs may have a preauthorization requirement or may result in a higher cost.<br>You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.<br>See the website listed for information on drugs covered by your plan. Not all drugs are covered.<br>Certain preventive medications and Tier 1 contraceptives are covered at No Charge. |
|                                                      | Tier 2 - Preferred brand drugs - Your Midrange-Cost Option                                                                                                                                        | Deductible does not apply. Retail:<br>\$45 <u>copay</u><br>Mail-Order:<br>\$112.50 <u>copay</u><br>Specialty Drugs:<br>\$125 <u>copay</u> | Deductible does not apply. Retail:<br>\$45 <u>copay</u>                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                      | Tier 3 - Non-preferred brand drugs - Your Midrange-Cost Option                                                                                                                                    | Deductible does not apply. Retail:<br>\$65 <u>copay</u><br>Mail-Order:<br>\$162.50 <u>copay</u><br>Specialty Drugs:<br>\$250 <u>copay</u> | Deductible does not apply. Retail:<br>\$65 <u>copay</u>                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                      | Tier 4 Specialty Drugs - Additional High-Cost Options                                                                                                                                             | Not Applicable                                                                                                                            | Not Applicable                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| If you have outpatient surgery                       | Facility fee (e.g., ambulatory surgery center)<br><br>Physician/surgeon fees<br><br>Emergency room care                                                                                           | 0% coinsurance<br><br>0% coinsurance<br><br>\$250 copay per visit, deductible does not apply                                              | 20% coinsurance<br><br>20% coinsurance<br><br>\$250 copay per visit, deductible does not apply | Preauthorization required for certain services for non-network or benefit reduces to 50% of allowed.<br><br>None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| If you need immediate medical attention              | Emergency medical transportation                                                                                                                                                                  | 0% coinsurance                                                                                                                            | 0% coinsurance                                                                                 | Network 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)          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                  | <u>Urgent care</u>                                                                                      | \$75 copay per visit, deductible does not apply                                                                                            | 20% coinsurance                                       | If you receive services in addition to <u>urgent care</u> visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)<br>Physician/surgeon fees                                            | 0% coinsurance<br>0% coinsurance                                                                                                           | 20% coinsurance<br>20% coinsurance                    | Preadmission required for non-network or benefit reduces to 50% of allowed.                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services<br><br>Inpatient services                                                           | \$50 copay per visit, deductible does not apply<br><br>0% coinsurance                                                                      | 20% coinsurance<br>20% coinsurance                    | Partial hospitalization/intensive outpatient treatment:<br>0% coinsurance<br>Preadmission required for certain services for non-network or benefit reduces to 50% of allowed.<br><br>Preadmission required for non-network or benefit reduces to 50% of allowed.                                                                                                                                                                                                                                                                    |
| <b>If you are pregnant</b>                                                       | Office visits<br><br>Childbirth/delivery professional services<br>Childbirth/delivery facility services | No Charge<br>0% coinsurance<br>0% coinsurance                                                                                              | 20% coinsurance<br>20% coinsurance<br>20% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of service a copayment, deductibles, or coinsurance may apply.<br><br>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)<br><br>Inpatient preauthorization may apply.                                                                                                                                                                                                                                       |
| <b>If you need help recovering or have other special health needs</b>            | Home health care<br><br>Rehabilitation services<br><br>Habilitation services                            | 0% coinsurance<br>\$25 copay per outpatient visit, deductible does not apply<br>\$25 copay per outpatient visit, deductible does not apply | 20% coinsurance<br>20% coinsurance<br>20% coinsurance | Limited to 60 visits per calendar year.<br>Preadmission required for non-network or benefit reduces to 50% of allowed.<br><br>Limits per calendar year: Physical Speech, Occupational, Pulmonary: 20 visits; Cardiac: 36 visits.<br>Preadmission required for certain services for non-network or benefit reduces to 50% of allowed.<br><br>Services provided under and limits are combined with Rehabilitation services above.<br>Preadmission required for certain services for non-network or benefit reduces to 50% of allowed. |

| 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) |                                                                                                                                                                                   |
| Skilled nursing care                   | Skilled nursing care       | 0% coinsurance                            | 20% coinsurance                              | Skilled Nursing is 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  | 0% coinsurance                            | 20% coinsurance                              | Covers 1 per type of DME (including repair/replace) every 3 years. Preauthorization required for non-network DME over \$1,000 or no coverage.                                     |
|                                        | Hospice services           | 0% coinsurance                            | 20% coinsurance                              | Preauthorization required for non-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.                                      |
| If your child needs dental or eye care | Children's eye exam        | Not Covered                               | Not Covered                                  | No coverage for Eye exam.                                                                                                                                                         |
|                                        | 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 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
- Infertility Treatment      • Long-Term Care      • Non-emergency care when traveling outside the U.S.      • Private-Duty Nursing (Adult/Child)
- Routine Foot Care      • Weight Loss Programs      • Hearing Aids

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
  - Hearing Aids
- 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](http://www.dol.gov/ebsa) for the U.S. Department of Labor, Employee Benefits Security Administration, or 1-877-267-2323 x61565 or [www.cms.gov](http://www.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](http://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: 1-800-782-3740; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Florida Department of Financial Services at 1-877-693-5236 or [www.myfloridacfo.com](http://www.myfloridacfo.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 1-800-782-3740.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-782-3740.

Navajo (Dine): Dine'ehgo shika at' ohwol minisingo, kwiijigo holne' 1-800-782-3740.

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

## About these Coverage Examples:



**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)

|                                        |         |
|----------------------------------------|---------|
| <b>The plan's overall deductible</b>   | \$3,000 |
| <b>Specialist Copayment</b>            | \$50    |
| <b>Hospital (facility) Coinsurance</b> | 0%      |
| <b>Other coinsurance</b>               | 0%      |

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

|                           |          |
|---------------------------|----------|
| <b>Total Example Cost</b> | \$12,800 |
|---------------------------|----------|

### In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$3,000        |
| Copayments                        | \$30           |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,090</b> |

### Managing Joe's type 2 Diabetes

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

|                                        |         |
|----------------------------------------|---------|
| <b>The plan's overall deductible</b>   | \$3,000 |
| <b>Specialist Copayment</b>            | \$50    |
| <b>Hospital (facility) Coinsurance</b> | 0%      |
| <b>Other coinsurance</b>               | 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*)

|                           |         |
|---------------------------|---------|
| <b>Total Example Cost</b> | \$7,400 |
|---------------------------|---------|

### In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$100          |
| Copayments                        | \$1,500        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$30           |
| <b>The total Joe would pay is</b> | <b>\$1,630</b> |

### Anna's Simple Fracture

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

|                                        |         |
|----------------------------------------|---------|
| <b>The plan's overall deductible</b>   | \$3,000 |
| <b>Specialist Copayment</b>            | \$50    |
| <b>Hospital (facility) Coinsurance</b> | 0%      |
| <b>Other coinsurance</b>               | 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*)

|                                    |                |
|------------------------------------|----------------|
| <b>Total Example Cost</b>          | \$1,900        |
| <i>Cost Sharing</i>                |                |
| Deductibles                        | \$700          |
| Copayments                         | \$400          |
| Coinsurance                        | \$0            |
| <i>What isn't covered</i>          |                |
| Limits or exclusions               | \$0            |
| <b>The total Anna would pay is</b> | <b>\$1,100</b> |

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 LUU 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 thô 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 ملخص **المزايا والتغطية** (Summary of Benefits and Coverage, SBC) هذا.

**ATANSYON:** Si w pale **Kreyòl ayisyen** (**Haitian Creole**), ou kapab benefisyè 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 हैं, आपको भाषा सहायता सेवाएं, निःशुल्क 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: ពីសិទ្ធិមួយកិច្ចភាពខ្លួន (Khmer) សេវាឌុំយកាសាខោយតារិកត្រួលដោះស្រាយប័ណ្ណការ ស្ថិតុកុំដ្ឋានខេត្តកោត្ត្រូវផ្ទើផ្លូវបានការតែងត្រួតពិនិត្យសម្រាប់មន្ត្រីប្រយោជន៍ និងការរំពោះ (Summary of Benefits and Coverage, SBC) ។

**PAKDAAR:** Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahé 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 Benipisyó ken Pannakasakup (Summary of Benefits and Coverage, SBC).

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

**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](http://www.welcometouhc.com) or by calling 1-800-782-3740. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-866-487-2365 to request a copy.

| Important Questions                                                | Answers                                                                                                                                          | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <u>What is the overall deductible?</u>                             | 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 <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have <u>other family members</u> on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.                                                                                      |
| <u>Are there services covered before you meet your deductible?</u> | Yes. Preventive care and categories with a <u>copay</u> are covered before you meet your deductible.                                             | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <u>Are there other deductibles for specific services?</u>          | No.                                                                                                                                              | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <u>What is the out-of-pocket limit for this plan?</u>              | Network: \$3,500 Individual / \$7,000 Family Non-Network: \$6,250 Individual / \$12,500 Family                                                   | The out-of-pocket limit is the most you could pay in a year for covered services. If you have <u>other family members</u> in this <u>plan</u> , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.                                                                                                                                                                                                                         |
| <u>What is not included in the out-of-pocket limit?</u>            | Premiums, <u>balance-billing</u> charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.                                                                                                                                                                                                                                                                                                                                                                                         |
| <u>Will you pay less if you use a network provider?</u>            | Yes. See <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> or call 1-800-782-3740 for a list of <u>network providers</u> .          | This <u>plan</u> uses a <u>provider network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.     |
| <u>Do you need a referral to see a specialist?</u>                 | No.                                                                                                                                              | You can see the specialist you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                   |



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                               | Non-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                 |
|--------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 | 40% coinsurance                              | Virtual visits (Telehealth) - \$25 copay per visit by a Designated Virtual Network Provider, deductible does not apply.<br>If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery. |
|                                                        | Specialist visit                                 | \$50 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 e.g. surgery.                                                                                                                            |
|                                                        | Preventive care/screening/immunization           | No Charge                                       | 40% 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)              | No Charge                                       | 40% coinsurance                              | Preauthorization required for non-network for certain services or benefit reduces to 50% of allowed.                                                                                                                                                   |
|                                                        | Imaging (CT/PET scans, MRIs)                     | 20% coinsurance                                 | 40% coinsurance                              | Preauthorization required for non-network or benefit reduces to 50% of allowed.                                                                                                                                                                        |

| 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 | Tier 1 - Generic drugs - Your Lowest-Cost Option<br><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> . | Deductible does not apply. Retail: \$10 copay<br>Mail-Order: \$25 copay<br>Specialty Drugs: \$10 copay     | Deductible does not apply. Retail: \$10 copay                           | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 31 day supply.<br>Mail-Order: Up to a 90 day supply.<br>If you use a non-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.<br><br>Copay is per prescription order up to the day supply limit listed above.<br><br>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.<br>Certain drugs may have a preauthorization requirement or may result in a higher cost.<br><br>You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.<br><br>See the website listed for information on drugs covered by your plan. Not all drugs are covered.<br>Certain preventive medications and Tier 1 contraceptives are covered at No Charge. |
|                                                      | Tier 2 - Preferred brand drugs - Your Midrange-Cost Option                                                                                                                                        | Deductible does not apply. Retail: \$35 copay<br>Mail-Order: \$87.50 copay<br>Specialty Drugs: \$100 copay | Deductible does not apply. Retail: \$35 copay                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                      | Tier 3 - Non-preferred brand drugs - Your Midrange-Cost Option                                                                                                                                    | Deductible does not apply. Retail: \$60 copay<br>Mail-Order: \$150 copay<br>Specialty Drugs: \$200 copay   | Deductible does not apply. Retail: \$60 copay                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                      | Tier 4 Specialty Drugs - Additional High-Cost Options                                                                                                                                             | Not Applicable                                                                                             | Not Applicable                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| If you have outpatient surgery                       | Facility fee (e.g., ambulatory surgery center)<br><br>Physician/surgeon fees                                                                                                                      | 20% coinsurance                                                                                            | 40% coinsurance                                                         | Preauthorization required for certain services for non-network or benefit reduces to 50% of allowed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| If you need immediate medical attention              | Emergency room care<br><br>Emergency medical transportation                                                                                                                                       | \$200 copay per visit, deductible does not apply<br><br>20% coinsurance                                    | \$200 copay per visit, deductible does not apply<br><br>20% coinsurance | None<br><br>Network 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)          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                  | <u>Urgent care</u>                                                                                  | \$75 copay per visit, deductible does not apply                                                                                             | 40% coinsurance                                       | If you receive services in addition to <u>urgent care</u> visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)<br>Physician/surgeon fees                                        | 20% coinsurance<br>\$50 copay per visit, deductible does not apply                                                                          | 40% coinsurance<br>40% coinsurance                    | Preaduthorization required for non-network or benefit reduces to 50% of allowed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services<br><br>Inpatient services                                                       | 20% coinsurance<br>\$50 copay per visit, deductible does not apply                                                                          | 40% coinsurance<br>40% coinsurance                    | <u>Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance</u><br>Preaduthorization required for certain services for non-network or benefit reduces to 50% of allowed.<br><br>Preaduthorization required for non-network or benefit reduces to 50% of allowed.                                                                                                                                                                                                                                                            |
| <b>If you are pregnant</b>                                                       | Office visits<br>Childbirth/delivery professional services<br>Childbirth/delivery facility services | No Charge<br>20% coinsurance<br>20% coinsurance                                                                                             | 40% coinsurance<br>40% coinsurance<br>40% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of service a copayment, deductibles, or coinsurance may apply.<br><br>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)<br><br>Inpatient preauthorization may apply.                                                                                                                                                                                                                                                      |
| <b>If you need help recovering or have other special health needs</b>            | Home health care<br><br>Rehabilitation services<br><br>Habilitation services                        | 20% coinsurance<br>\$25 copay per outpatient visit, deductible does not apply<br>\$25 copay per outpatient visit, deductible does not apply | 40% coinsurance<br>40% coinsurance<br>40% coinsurance | Limited to 60 visits per calendar year.<br>Preaduthorization required for non-network or benefit reduces to 50% of allowed.<br><br>Limits per calendar year: Physical Speech, Occupational, Pulmonary: 20 visits; Cardiac: 36 visits.<br>Preaduthorization required for certain services for non-network or benefit reduces to 50% of allowed.<br><br>Services provided under and limits are combined with Rehabilitation services above.<br>Preaduthorization required for certain services for non-network or benefit reduces to 50% of allowed. |

| 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) |                                                                                                                                                                                   |
| Skilled nursing care                   | Skilled nursing care       | 20% coinsurance                           | 40% coinsurance                              | Skilled Nursing is 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                           | 40% coinsurance                              | Covers 1 per type of DME (including repair/replace) every 3 years. Preauthorization required for non-network DME over \$1,000 or no coverage.                                     |
|                                        | Hospice services           | 20% coinsurance                           | 40% coinsurance                              | Preauthorization required for non-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.                                      |
| If your child needs dental or eye care | Children's eye exam        | Not Covered                               | Not Covered                                  | No coverage for Eye exam.                                                                                                                                                         |
|                                        | 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 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
- Infertility Treatment      • Long-Term Care      • Non-emergency care when traveling outside the U.S.      • Private-Duty Nursing (Adult/Child)
- Routine Foot Care      • Weight Loss Programs      • Hearing Aids

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
  - Hearing Aids
- 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](http://www.dol.gov/ebsa) for the U.S. Department of Labor, Employee Benefits Security Administration, or 1-877-267-2323 x61565 or [www.cms.gov](http://www.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](http://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: 1-800-782-3740; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Florida Department of Financial Services at 1-877-693-5236 or [www.myfloridacfo.com](http://www.myfloridacfo.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 1-800-782-3740.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-782-3740.

Navajo (Dine): Dine'ehgo shika at' ohwol minisingo, kwiijigo holne' 1-800-782-3740.

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

## About these Coverage Examples:

**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            | \$50    |
| ■ Hospital (facility) Coinsurance | 20%     |
| ■ Other coinsurance               | 20%     |

This EXAMPLE event includes services like:  
 Specialist office visits (*pregnatal 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                      | \$30     |
| Coinsurance                     | \$1,800  |
| What isn't covered              |          |
| Limits or exclusions            | \$60     |
| The total Peg would pay is      | \$2,890  |

### 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            | \$50    |
| ■ 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, Anna would pay: |         |
| Cost Sharing                     |         |
| Deductibles                      | \$700   |
| Copayments                       | \$300   |
| Coinsurance                      | \$0     |
| What isn't covered               |         |
| Limits or exclusions             | \$0     |
| The total Anna would pay is      | \$1,000 |

### Anna's Simple Fracture

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

|                                   |         |
|-----------------------------------|---------|
| ■ The plan's overall deductible   | \$1,000 |
| ■ Specialist Copayment            | \$50    |
| ■ 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, Anna would pay: |         |
| Cost Sharing                     |         |
| Deductibles                      | \$700   |
| Copayments                       | \$300   |
| Coinsurance                      | \$0     |
| What isn't covered               |         |
| Limits or exclusions             | \$0     |
| The total Anna would pay is      | \$1,000 |

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 LUU 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 thô 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 ملخص **المزايا والتغطية** (Summary of Benefits and Coverage, SBC) هذا.

**ATANSYON:** Si w pale **Kreyòl ayisyen** (**Haitian Creole**), ou kapab benefisyè 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 हैं, आपको भाषा सहायता सेवाएं, निःशुल्क 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:** ពីសិទ្ធិមួយកិច្ចាសាស្ត្រ (Khmer) សេវាឌុំយកាសាខោយតារិកត្រួលដោះស្រាយនៃប្រព័ន្ធដូចជា សេវាឌុំសង្គមត្រួលដោះស្រាយ (Summary of Benefits and Coverage, SBC) ។

**PAKDAAR:** Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahé 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 Benipisyó ken Pannakasakup (Summary of Benefits and Coverage, SBC).

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

**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).

| Important Questions                                                | Answers                                                                                                                                   | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | Network: \$1,500 Individual / \$4,500 Family Non-Network: \$3,000 Individual / \$9,000 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.                                                                                              |
| <b>Are there services covered before you meet your deductible?</b> | 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. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <b>Are there other deductibles for specific services?</b>          | No.                                                                                                                                       | You don't have to meet deductibles for specific services.                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>What is the out-of-pocket limit for this plan?</b>              | 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.                                                                                                                                                                                              |
| <b>What is not included in the out-of-pocket limit?</b>            | Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services. | Even though you pay these expenses, they don't count toward the out-of-pocket limit.                                                                                                                                                                                                                                                                                                                                                      |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> or call 1-800-782-3740 for a list of network providers.           | This plan uses a provider 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.                                     |
| <b>Do you need a referral to see a specialist?</b>                 | 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                               | Non-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                 |
|--------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 | 20% coinsurance                              | Virtual visits (Telehealth) - \$25 copay per visit by a Designated Virtual Network Provider, deductible does not apply.<br>If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery. |
|                                                        | Specialist visit                                                    | \$50 copay per visit, deductible does not apply | 20% coinsurance                              | If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.                                                                                                                            |
| Preventive care/screening/immunization                 |                                                                     | No Charge                                       | 20% 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)<br>Imaging (CT/PET scans, MRIs) | No Charge<br>0% coinsurance                     | 20% coinsurance<br>20% coinsurance           | Preauthorization required for non-network for certain services or benefit reduces to 50% of allowed.<br>Preauthorization required for non-network or benefit reduces to 50% of allowed.                                                                |

| 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 | Tier 1 - Generic drugs - Your Lowest-Cost Option<br><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> . | Deductible does not apply. Retail:<br>\$15 <u>copay</u><br>Mail-Order:<br>\$37.50 <u>copay</u><br>Specialty Drugs:<br>\$15 <u>copay</u>   | Deductible does not apply. Retail:<br>\$15 <u>copay</u>                                        | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 31 day supply.<br>Mail-Order: Up to a 90 day supply.<br>If you use a non-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.<br><u>Copay</u> is per prescription order up to the day supply limit listed above.<br>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.<br>Certain drugs may have a preauthorization requirement or may result in a higher cost.<br>You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.<br>See the website listed for information on drugs covered by your plan. Not all drugs are covered.<br>Certain preventive medications and Tier 1 contraceptives are covered at No Charge. |
|                                                      | Tier 2 - Preferred brand drugs - Your Midrange-Cost Option                                                                                                                                        | Deductible does not apply. Retail:<br>\$45 <u>copay</u><br>Mail-Order:<br>\$112.50 <u>copay</u><br>Specialty Drugs:<br>\$125 <u>copay</u> | Deductible does not apply. Retail:<br>\$45 <u>copay</u>                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                      | Tier 3 - Non-preferred brand drugs - Your Midrange-Cost Option                                                                                                                                    | Deductible does not apply. Retail:<br>\$65 <u>copay</u><br>Mail-Order:<br>\$162.50 <u>copay</u><br>Specialty Drugs:<br>\$250 <u>copay</u> | Deductible does not apply. Retail:<br>\$65 <u>copay</u>                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                      | Tier 4 Specialty Drugs - Additional High-Cost Options                                                                                                                                             | Not Applicable                                                                                                                            | Not Applicable                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| If you have outpatient surgery                       | Facility fee (e.g., ambulatory surgery center)<br><br>Physician/surgeon fees<br><br>Emergency room care                                                                                           | 0% coinsurance<br><br>0% coinsurance<br><br>\$200 copay per visit, deductible does not apply                                              | 20% coinsurance<br><br>20% coinsurance<br><br>\$200 copay per visit, deductible does not apply | Preauthorization required for certain services for non-network or benefit reduces to 50% of allowed.<br><br>None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| If you need immediate medical attention              | Emergency medical transportation                                                                                                                                                                  | 0% coinsurance                                                                                                                            | 0% coinsurance                                                                                 | Network 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)          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                  | <u>Urgent care</u>                                                                                      | \$75 copay per visit, deductible does not apply                                                                                                    | 20% coinsurance                                       | If you receive services in addition to <u>urgent care</u> visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)<br>Physician/surgeon fees                                            | 0% coinsurance<br>0% coinsurance                                                                                                                   | 20% coinsurance<br>20% coinsurance                    | Preadmission required for non-network or benefit reduces to 50% of allowed.                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services<br><br>Inpatient services                                                           | \$50 copay per visit, deductible does not apply<br><br>0% coinsurance                                                                              | 20% coinsurance<br>20% coinsurance                    | Partial hospitalization/intensive outpatient treatment:<br>0% coinsurance<br>Preadmission required for certain services for non-network or benefit reduces to 50% of allowed.<br><br>Preadmission required for non-network or benefit reduces to 50% of allowed.                                                                                                                                                                                                                                                                    |
| <b>If you are pregnant</b>                                                       | Office visits<br><br>Childbirth/delivery professional services<br>Childbirth/delivery facility services | No Charge<br><br>0% coinsurance<br>0% coinsurance                                                                                                  | 20% coinsurance<br>20% coinsurance<br>20% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of service a copayment, deductibles, or coinsurance may apply.<br><br>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)<br><br>Inpatient preauthorization may apply.                                                                                                                                                                                                                                       |
| <b>If you need help recovering or have other special health needs</b>            | Home health care<br><br>Rehabilitation services<br><br>Habilitation services                            | 0% coinsurance<br><br>\$25 copay per outpatient visit, deductible does not apply<br><br>\$25 copay per outpatient visit, deductible does not apply | 20% coinsurance<br>20% coinsurance<br>20% coinsurance | Limited to 60 visits per calendar year.<br>Preadmission required for non-network or benefit reduces to 50% of allowed.<br><br>Limits per calendar year: Physical Speech, Occupational, Pulmonary: 20 visits; Cardiac: 36 visits.<br>Preadmission required for certain services for non-network or benefit reduces to 50% of allowed.<br><br>Services provided under and limits are combined with Rehabilitation services above.<br>Preadmission required for certain services for non-network or benefit reduces to 50% of allowed. |

| 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) |                                                                                                                                                                                   |
| Skilled nursing care                   | Skilled nursing care       | 0% coinsurance                            | 20% coinsurance                              | Skilled Nursing is 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  | 0% coinsurance                            | 20% coinsurance                              | Covers 1 per type of DME (including repair/replace) every 3 years. Preauthorization required for non-network DME over \$1,000 or no coverage.                                     |
|                                        | Hospice services           | 0% coinsurance                            | 20% coinsurance                              | Preauthorization required for non-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.                                      |
| If your child needs dental or eye care | Children's eye exam        | Not Covered                               | Not Covered                                  | No coverage for Eye exam.                                                                                                                                                         |
|                                        | 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 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
- Infertility Treatment      • Long-Term Care      • Non-emergency care when traveling outside the U.S.      • Private-Duty Nursing (Adult/Child)
- Routine Foot Care      • Weight Loss Programs      • Hearing Aids

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
  - Hearing Aids
- 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](http://www.dol.gov/ebsa) for the U.S. Department of Labor, Employee Benefits Security Administration, or 1-877-267-2323 x61565 or [www.cms.gov](http://www.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](http://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: 1-800-782-3740; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Florida Department of Financial Services at 1-877-693-5236 or [www.myfloridacfo.com](http://www.myfloridacfo.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 1-800-782-3740.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-782-3740.

Navajo (Dine): Dine'ehgo shika at' ohwol minisingo, kwiijigo holne' 1-800-782-3740.

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

## About these Coverage Examples:

**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)

|                                        |         |
|----------------------------------------|---------|
| <b>The plan's overall deductible</b>   | \$1,500 |
| <b>Specialist Copayment</b>            | \$50    |
| <b>Hospital (facility) Coinsurance</b> | 0%      |
| <b>Other coinsurance</b>               | 0%      |

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

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | \$12,800       |
| <b>In this example, Peg would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| Deductibles                            | \$1,500        |
| Copayments                             | \$30           |
| Coinsurance                            | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$60           |
| <b>The total Peg would pay is</b>      | <b>\$1,590</b> |

### Managing Joe's type 2 Diabetes

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

|                                        |         |
|----------------------------------------|---------|
| <b>The plan's overall deductible</b>   | \$1,500 |
| <b>Specialist Copayment</b>            | \$50    |
| <b>Hospital (facility) Coinsurance</b> | 0%      |
| <b>Other coinsurance</b>               | 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*)

|                                         |                |
|-----------------------------------------|----------------|
| <b>Total Example Cost</b>               | \$7,400        |
| <b>In this example, Anna would pay:</b> |                |
| <i>Cost Sharing</i>                     |                |
| Deductibles                             | \$700          |
| Copayments                              | \$300          |
| Coinsurance                             | \$0            |
| <i>What isn't covered</i>               |                |
| Limits or exclusions                    | \$0            |
| <b>The total Anna would pay is</b>      | <b>\$1,000</b> |

### Anna's Simple Fracture

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

|                                        |         |
|----------------------------------------|---------|
| <b>The plan's overall deductible</b>   | \$1,500 |
| <b>Specialist Copayment</b>            | \$50    |
| <b>Hospital (facility) Coinsurance</b> | 0%      |
| <b>Other coinsurance</b>               | 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*)

|                                         |                |
|-----------------------------------------|----------------|
| <b>Total Example Cost</b>               | \$1,900        |
| <b>In this example, Anna would pay:</b> |                |
| <i>Cost Sharing</i>                     |                |
| Deductibles                             | \$700          |
| Copayments                              | \$300          |
| Coinsurance                             | \$0            |
| <i>What isn't covered</i>               |                |
| Limits or exclusions                    | \$0            |
| <b>The total Anna would pay is</b>      | <b>\$1,000</b> |

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 LUU 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 thô 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 ملخص **المزايا والتغطية** (Summary of Benefits and Coverage, SBC) هذا.

**ATANSYON:** Si w pale **Kreyòl ayisyen** (**Haitian Creole**), ou kapab benefisyè 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 हैं, आपको भाषा सहायता सेवाएं, निःशुल्क 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: ពីសិទ្ធិមួយកិច្ចភាពខ្លួន (Khmer) សេវាឌុំយកាសាខោយតារិកត្រួតពិនិត្យសំរាប់មួយក្រុងប្រព័ន្ធដែលមានសេវាឌុំយកាសាខោយតារិកត្រួតពិនិត្យសំរាប់មួយក្រុងប្រព័ន្ធ (Summary of Benefits and Coverage, SBC) ។

**PAKDAAR:** Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahé 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 Benipisyó ken Pannakasakup (Summary of Benefits and Coverage, SBC).

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

**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).

**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**  
**UnitedHealthcare® Choice Plus AHLV /128**  
**Insurance Company**

**Coverage Period:** 06/01/2017 - 05/31/2018  
**Coverage for:** Employee/Family | **Plan Type:** POS

**!** 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](http://www.welcometouhc.com) or by calling 1-800-782-3740. 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](http://www.cciio.cms.gov) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-866-487-2365 to request a copy.

| Important Questions                                                | Answers                                                                                                                                          | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <u>What is the overall deductible?</u>                             | Network: \$2,000 Individual / \$6,000 Family Non-Network: \$4,000 Individual / \$12,000 Family Per calendar year.                                | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have <u>other family members</u> on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.                                                                                      |
| <u>Are there services covered before you meet your deductible?</u> | Yes. Preventive care and categories with a <u>copay</u> are covered before you meet your deductible.                                             | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <u>Are there other deductibles for specific services?</u>          | No.                                                                                                                                              | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <u>What is the out-of-pocket limit for this plan?</u>              | Network: \$4,000 Individual / \$12,000 Family Non-Network: \$6,250 Individual / \$12,500 Family                                                  | The out-of-pocket limit is the most you could pay in a year for covered services. If you have <u>other family members</u> in this <u>plan</u> , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.                                                                                                                                                                                                                         |
| <u>What is not included in the out-of-pocket limit?</u>            | Premiums, <u>balance-billing</u> charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.                                                                                                                                                                                                                                                                                                                                                                                         |
| <u>Will you pay less if you use a network provider?</u>            | Yes. See <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> or call 1-800-782-3740 for a list of <u>network providers</u> .          | This <u>plan</u> uses a <u>provider network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.     |
| <u>Do you need a referral to see a specialist?</u>                 | No.                                                                                                                                              | You can see the specialist you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                   |



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                               | Non-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                 |
|--------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 | 20% coinsurance                              | Virtual visits (Telehealth) - \$25 copay per visit by a Designated Virtual Network Provider, deductible does not apply.<br>If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery. |
|                                                        | Specialist visit                                                    | \$50 copay per visit, deductible does not apply | 20% coinsurance                              | If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.                                                                                                                            |
| Preventive care/screening/immunization                 |                                                                     | No Charge                                       | 20% 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)<br>Imaging (CT/PET scans, MRIs) | No Charge<br>0% coinsurance                     | 20% coinsurance<br>20% coinsurance           | Preauthorization required for non-network for certain services or benefit reduces to 50% of allowed.<br>Preauthorization required for non-network or benefit reduces to 50% of allowed.                                                                |

| 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 | Tier 1 - Generic drugs - Your Lowest-Cost Option<br><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> . | Deductible does not apply. Retail:<br>\$15 <u>copay</u><br>Mail-Order:<br>\$37.50 <u>copay</u><br>Specialty Drugs:<br>\$15 <u>copay</u>   | Deductible does not apply. Retail:<br>\$15 <u>copay</u>                                        | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 31 day supply.<br>Mail-Order: Up to a 90 day supply.<br>If you use a non-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.<br><u>Copay</u> is per prescription order up to the day supply limit listed above.<br>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.<br>Certain drugs may have a preauthorization requirement or may result in a higher cost.<br>You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.<br>See the website listed for information on drugs covered by your plan. Not all drugs are covered.<br>Certain preventive medications and Tier 1 contraceptives are covered at No Charge. |
|                                                      | Tier 2 - Preferred brand drugs - Your Midrange-Cost Option                                                                                                                                        | Deductible does not apply. Retail:<br>\$45 <u>copay</u><br>Mail-Order:<br>\$112.50 <u>copay</u><br>Specialty Drugs:<br>\$125 <u>copay</u> | Deductible does not apply. Retail:<br>\$45 <u>copay</u>                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                      | Tier 3 - Non-preferred brand drugs - Your Midrange-Cost Option                                                                                                                                    | Deductible does not apply. Retail:<br>\$65 <u>copay</u><br>Mail-Order:<br>\$162.50 <u>copay</u><br>Specialty Drugs:<br>\$250 <u>copay</u> | Deductible does not apply. Retail:<br>\$65 <u>copay</u>                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                      | Tier 4 Specialty Drugs - Additional High-Cost Options                                                                                                                                             | Not Applicable                                                                                                                            | Not Applicable                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| If you have outpatient surgery                       | Facility fee (e.g., ambulatory surgery center)<br><br>Physician/surgeon fees<br><br>Emergency room care                                                                                           | 0% coinsurance<br><br>0% coinsurance<br><br>\$200 copay per visit, deductible does not apply                                              | 20% coinsurance<br><br>20% coinsurance<br><br>\$200 copay per visit, deductible does not apply | Preauthorization required for certain services for non-network or benefit reduces to 50% of allowed.<br><br>None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| If you need immediate medical attention              | Emergency medical transportation                                                                                                                                                                  | 0% coinsurance                                                                                                                            | 0% coinsurance                                                                                 | Network 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)          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                  | <u>Urgent care</u>                                                                                      | \$75 copay per visit, deductible does not apply                                                                                            | 20% coinsurance                                       | If you receive services in addition to <u>urgent care</u> visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)<br>Physician/surgeon fees                                            | 0% coinsurance<br>0% coinsurance                                                                                                           | 20% coinsurance<br>20% coinsurance                    | Preauthorization required for non-network or benefit reduces to 50% of allowed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services<br><br>Inpatient services                                                           | \$50 copay per visit, deductible does not apply<br><br>0% coinsurance                                                                      | 20% coinsurance<br>20% coinsurance                    | Partial hospitalization/intensive outpatient treatment:<br>0% coinsurance<br>Preauthorization required for certain services for non-network or benefit reduces to 50% of allowed.<br><br>Preauthorization required for non-network or benefit reduces to 50% of allowed.                                                                                                                                                                                                                                                                        |
| <b>If you are pregnant</b>                                                       | Office visits<br><br>Childbirth/delivery professional services<br>Childbirth/delivery facility services | No Charge<br>0% coinsurance<br>0% coinsurance                                                                                              | 20% coinsurance<br>20% coinsurance<br>20% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of service a copayment, deductibles, or coinsurance may apply.<br><br>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)<br><br>Inpatient preauthorization may apply.                                                                                                                                                                                                                                                   |
| <b>If you need help recovering or have other special health needs</b>            | Home health care<br><br>Rehabilitation services<br><br>Habilitation services                            | 0% coinsurance<br>\$25 copay per outpatient visit, deductible does not apply<br>\$25 copay per outpatient visit, deductible does not apply | 20% coinsurance<br>20% coinsurance<br>20% coinsurance | Limited to 60 visits per calendar year.<br>Preauthorization required for non-network or benefit reduces to 50% of allowed.<br><br>Limits per calendar year: Physical Speech, Occupational, Pulmonary: 20 visits; Cardiac: 36 visits.<br>Preauthorization required for certain services for non-network or benefit reduces to 50% of allowed.<br><br>Services provided under and limits are combined with Rehabilitation services above.<br>Preauthorization required for certain services for non-network or benefit reduces to 50% of allowed. |

| 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) |                                                                                                                                                                                   |
| Skilled nursing care                   | Skilled nursing care       | 0% coinsurance                            | 20% coinsurance                              | Skilled Nursing is 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  | 0% coinsurance                            | 20% coinsurance                              | Covers 1 per type of DME (including repair/replace) every 3 years. Preauthorization required for non-network DME over \$1,000 or no coverage.                                     |
|                                        | Hospice services           | 0% coinsurance                            | 20% coinsurance                              | Preauthorization required for non-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.                                      |
| If your child needs dental or eye care | Children's eye exam        | Not Covered                               | Not Covered                                  | No coverage for Eye exam.                                                                                                                                                         |
|                                        | 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 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
- Infertility Treatment      • Long-Term Care      • Non-emergency care when traveling outside the U.S.      • Private-Duty Nursing (Adult/Child)
- Routine Foot Care      • Weight Loss Programs      • Hearing Aids

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
  - Hearing Aids
- 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](http://www.dol.gov/ebsa) for the U.S. Department of Labor, Employee Benefits Security Administration, or 1-877-267-2323 x61565 or [www.cms.gov](http://www.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](http://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: 1-800-782-3740; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Florida Department of Financial Services at 1-877-693-5236 or [www.myfloridacfo.com](http://www.myfloridacfo.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 1-800-782-3740.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-782-3740.

Navajo (Dine): Dine'ehgo shika at' ohwol minisingo, kwiijigo holne' 1-800-782-3740.

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

## About these Coverage Examples:

**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)

|                                        |         |
|----------------------------------------|---------|
| <b>The plan's overall deductible</b>   | \$2,000 |
| <b>Specialist Copayment</b>            | \$50    |
| <b>Hospital (facility) Coinsurance</b> | 0%      |
| <b>Other coinsurance</b>               | 0%      |

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

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | \$12,800       |
| <b>In this example, Peg would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| Deductibles                            | \$2,000        |
| Copayments                             | \$30           |
| Coinurance                             | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$60           |
| <b>The total Peg would pay is</b>      | <b>\$2,090</b> |

### Managing Joe's type 2 Diabetes

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

|                                        |         |
|----------------------------------------|---------|
| <b>The plan's overall deductible</b>   | \$2,000 |
| <b>Specialist Copayment</b>            | \$50    |
| <b>Hospital (facility) Coinsurance</b> | 0%      |
| <b>Other coinsurance</b>               | 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*)

|                                         |                |
|-----------------------------------------|----------------|
| <b>Total Example Cost</b>               | \$7,400        |
| <b>In this example, Anna would pay:</b> |                |
| <i>Cost Sharing</i>                     |                |
| Deductibles                             | \$700          |
| Copayments                              | \$300          |
| Coinurance                              | \$0            |
| <i>What isn't covered</i>               |                |
| Limits or exclusions                    | \$0            |
| <b>The total Anna would pay is</b>      | <b>\$1,000</b> |

### Anna's Simple Fracture

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

|                                        |         |
|----------------------------------------|---------|
| <b>The plan's overall deductible</b>   | \$2,000 |
| <b>Specialist Copayment</b>            | \$50    |
| <b>Hospital (facility) Coinsurance</b> | 0%      |
| <b>Other coinsurance</b>               | 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*)

|                                         |                |
|-----------------------------------------|----------------|
| <b>Total Example Cost</b>               | \$1,900        |
| <b>In this example, Anna would pay:</b> |                |
| <i>Cost Sharing</i>                     |                |
| Deductibles                             | \$700          |
| Copayments                              | \$300          |
| Coinurance                              | \$0            |
| <i>What isn't covered</i>               |                |
| Limits or exclusions                    | \$0            |
| <b>The total Anna would pay is</b>      | <b>\$1,000</b> |

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 LUU 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 thô 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 ملخص **المزايا والتغطية** (Summary of Benefits and Coverage, SBC) هذا.

**ATANSYON:** Si w pale **Kreyòl ayisyen** (**Haitian Creole**), ou kapab benefisyè 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 हैं, आपको भाषा सहायता सेवाएं, निःशुल्क 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:** ពីសិទ្ធិមួយកិច្ចភាពខ្លួន (Khmer) សេវាឌុំយកាសាខោយតារិកត្រួតពិនិត្យសំរាប់មួយក្រុងប្រព័ន្ធដែលមានសេវាឌុំយកាសាខោយតារិកត្រួតពិនិត្យសំរាប់មួយក្រុងប្រព័ន្ធ (Summary of Benefits and Coverage, SBC) ។

**PAKDAAR:** Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahé 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 Benipisyó ken Pannakasakup (Summary of Benefits and Coverage, SBC).

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

**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).

**Plan Description:** Guardian Value Midwest  
**Product:** PPO  
**Network:** DentalGuard Preferred

**Provider:** Guardian Life Ins. Company  
**Member Services Phone #:** 1-800-541-7846  
**Plan Website Address:** <http://www.guardiananytime.com>

| Benefit                                     | In-Network                                                                         | Out-of-Network                                                                     |
|---------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| <b>Deductibles &amp; Maximum Amounts</b>    |                                                                                    |                                                                                    |
| Calendar Year Benefit Maximum               | • \$1,000                                                                          | • \$1,000                                                                          |
| Calendar Year Deductible - Individual       | • \$50                                                                             | • \$50                                                                             |
| Calendar Year Deductible - Family           | • \$150                                                                            | • \$150                                                                            |
| <b>Preventive &amp; Diagnostic Services</b> |                                                                                    |                                                                                    |
| Preventive & Diagnostic Services            | • 100%                                                                             | • 100% of In-Network Established Fee                                               |
| <b>Basic / Restorative Services</b>         |                                                                                    |                                                                                    |
| Basic / Restorative Services                | • Deductible then 80%                                                              | • Deductible then 80% of In-Network Established Fee                                |
| <b>Major Services</b>                       |                                                                                    |                                                                                    |
| Major Services                              | • Deductible then 50%                                                              | • Deductible then 50% of In-Network Established Fee                                |
| <b>Orthodontic Services</b>                 |                                                                                    |                                                                                    |
| Orthodontic Lifetime Maximum                | • \$1,000 lifetime maximum for child(ren) under age 19.<br>Adult ortho not covered | • \$1,000 lifetime maximum for child(ren) under age 19.<br>Adult ortho not covered |
| Orthodontic Deductible                      | • None                                                                             | • None                                                                             |
| Orthodontic Coinsurance                     | • 50%                                                                              | • 50% of In-Network Established Fee                                                |
| Diagnosis                                   | • 50%                                                                              | • 50% of In-Network Established Fee                                                |
| Initial Placement of Orthodontic Appliance  | • Covered as part of Active and Retention Treatments                               | • Covered as part of Active and Retention Treatments                               |
| Active and Retention Treatments             | • 50%                                                                              | • 50% of In-Network Established Fee                                                |
| <b>Services</b>                             |                                                                                    |                                                                                    |
| Oral Examination Copay / Coinsurance        | • 100%                                                                             | • 100% of In-Network Established Fee                                               |
| Dental X-Rays                               | • 100%                                                                             | • 100% of In-Network Established Fee                                               |
| Prophylaxis - Adult                         | • 100%                                                                             | • 100% of In-Network Established Fee                                               |
| Prophylaxis - Child                         | • 100%                                                                             | • 100% of In-Network Established Fee                                               |
| Topical Application of Fluoride             | • 100%                                                                             | • 100% of In-Network Established Fee                                               |
| Topical Application of Sealants             | • 100%                                                                             | • 100% of In-Network Established Fee                                               |
| Filings                                     | • Deductible then 80%                                                              | • Deductible then 80% of In-Network Established Fee                                |
| Periodontic Services                        | • Deductible then 80%                                                              | • Deductible then 80% of In-Network Established Fee                                |
| Extractions                                 | • Simple and Surgical Extractions: Deductible then 80%                             | • Deductible then 80% of In-Network Established Fee                                |
| Endodontics                                 | • Deductible then 80%                                                              | • Deductible then 80% of In-Network Established Fee                                |
| Oral Surgery                                | • Deductible then 80%                                                              | • Deductible then 80% of In-Network Established Fee                                |
| Inlays                                      | • Deductible then 50%                                                              | • Deductible then 50% of In-Network Established Fee                                |
| Crowns                                      | • Deductible then 50%                                                              | • Deductible then 50% of In-Network Established Fee                                |
| Dentures                                    | • Deductible then 50%                                                              | • Deductible then 50% of In-Network Established Fee                                |
| Bridges                                     | • Deductible then 50%                                                              | • Deductible then 50% of In-Network Established Fee                                |

This benefit summary has been prepared by a licensed insurance carrier or broker based on documents provided by the applicable licensed insurance carrier. Please refer to the Plan Document and Certificate of Coverage (COC) for terms and conditions of all benefits. Benefits may require pre-certification in order to avoid a reduction in benefits or denial of coverage. The insured should contact the carrier at the phone number indicated on this summary or refer to the COC for further details prior to seeking treatment. If there is any conflict between this benefit summary and the Plan Document or COC, the Plan Document and COC govern. This health insurance plan is part of a large group health plan, as such Medicare is the secondary payer for any insured member that is enrolled in Medicare and this plan. If eligible for Medicare due to ESRD, Medicare becomes primary payer after thirty months of Medicare eligibility. If member is a COBRA participant, Medicare is the primary payer.



## Get the best in eyecare and eyewear with ADP TOTAL SOURCE and VSP® Vision Care.

Why enroll in VSP? We invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness first.

### You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP provider including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

### Using your VSP benefit is easy.

- **Register at [vsp.com](http://vsp.com).**  
Once your plan is effective, review your benefit information.
- **Find an eyecare provider who's right for you.**  
To find a VSP provider, visit [vsp.com](http://vsp.com) or call 800.877.7195.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on [vsp.com](http://vsp.com).

**That's it! We'll handle the rest**—there are no claim forms to complete when you see a VSP provider.

### Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more<sup>1</sup>. Visit [vsp.com](http://vsp.com) to find a VSP provider who carries these brands.

Enroll in VSP today.  
You'll be glad you did.

Contact us. **800.877.7195**  
[vsp.com](http://vsp.com)



# Your VSP Vision Benefits Summary

ADP TOTAL SOURCE and VSP provide you with an affordable eyecare plan.

**VSP Coverage Effective Date:** 06/01/2017

**VSP Provider Network:** VSP Choice

Visit [vsp.com](http://vsp.com) for more details on your vision benefit and for exclusive savings and promotions for VSP members.

| Benefit                                  | Description                                                                                                                                                                                                                                                                                                                                       | Copay                                 | Frequency        |
|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|------------------|
| <b>Your Coverage with a VSP Provider</b> |                                                                                                                                                                                                                                                                                                                                                   |                                       |                  |
| WellVision Exam                          | <ul style="list-style-type: none"> <li>Focuses on your eyes and overall wellness</li> </ul>                                                                                                                                                                                                                                                       | \$10                                  | Every plan year* |
| <b>Prescription Glasses</b>              |                                                                                                                                                                                                                                                                                                                                                   |                                       |                  |
| Frame                                    | <ul style="list-style-type: none"> <li>\$180 allowance for a wide selection of frames</li> <li>20% savings on the amount over your allowance</li> <li>\$100 Costco or Walmart allowance</li> </ul>                                                                                                                                                | Included in Prescription Glasses      | Every plan year  |
| Lenses                                   | <ul style="list-style-type: none"> <li>Single vision, lined bifocal, and lined trifocal lenses</li> <li>Polycarbonate lenses for dependent children</li> </ul>                                                                                                                                                                                    | Included in Prescription Glasses      | Every plan year  |
| Lens Enhancements                        | <ul style="list-style-type: none"> <li>Standard progressive lenses</li> <li>Premium progressive lenses</li> <li>Custom progressive lenses</li> <li>Average savings of 20-25% on other lens enhancements</li> </ul>                                                                                                                                | \$55<br>\$95 - \$105<br>\$150 - \$175 | Every plan year  |
| Contacts (instead of glasses)            | <ul style="list-style-type: none"> <li>\$150 allowance for contacts and contact lens exam (fitting and evaluation)</li> <li>15% savings on a contact lens exam (fitting and evaluation)</li> </ul>                                                                                                                                                | \$0                                   | Every plan year  |
| Laser VisionCare Preferred Program       | <ul style="list-style-type: none"> <li>\$150 allowance both eyes for LASIK, Custom LASIK, and PRK.</li> <li>Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.</li> <li>After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.</li> </ul> | \$0                                   | Every plan year  |
| Extra Savings                            | <b>Glasses and Sunglasses</b> <ul style="list-style-type: none"> <li>20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.</li> </ul>                                                                                                               |                                       |                  |

## Your Coverage with Out-of-Network Providers

Visit [vsp.com](http://vsp.com) for details, if you plan to see a provider other than a VSP network provider.

|            |            |                           |            |                            |            |               |             |
|------------|------------|---------------------------|------------|----------------------------|------------|---------------|-------------|
| Exam.....  | up to \$45 | Single Vision Lenses..... | up to \$45 | Lined Trifocal Lenses..... | up to \$85 | Contacts..... | up to \$150 |
| Frame..... | up to \$70 | Lined Bifocal Lenses..... | up to \$65 | Progressive Lenses.....    | up to \$65 |               |             |

\* Plan year begins in June

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

**Enroll in VSP today. You'll be glad you did.**

Contact us. **800.877.7195**

**[vsp.com](http://vsp.com)**

<sup>1</sup> Brands/Promotion subject to change.  
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## ADP TotalSource (# 866285)

Plan Year: 2017/2018

### Summary of Group Term Life and Accidental Death and Personal Loss (AD&PL) Benefits

#### Basic Life 10K

#### Am I eligible for coverage?

You qualify if you are an actively-at-work employee working 30 hours or more per week in an eligible class as defined by your worksite employer.

Your coverage will begin on the first day of the month coinciding with or following completion of your worksite employer's waiting period; or the day the worksite employer becomes covered under the plan. If you are not actively-at-work on the effective date, your coverage will not take effect until you return to active work for one full day.

#### What is Life and AD&PL coverage?

**Group Term Life Insurance** helps provide financial protection for those who rely on your income if something happens to you. Term life insurance is a simple form of life insurance, which builds no cash value.

**AD&PL** pays a benefit in addition to your life insurance, if you die as a result of an accident. Additional benefits are also paid for loss of limb or sight or hearing or speech, and other serious injuries or conditions, like paralysis or coma, caused by an accident.

#### How much coverage does my employer provide?

##### Employer-Paid - Term Life

**You:** a flat amount of \$10,000

##### Employer-Paid - AD&PL

**You:** a flat amount of \$10,000

#### What additional features should I know about?

**Continuation of Life Insurance**  
for permanently and totally disabled employees

If you are unable to work at any job due to an injury or illness for an extended period of time, you may be eligible to have your life insurance coverage continued without paying premiums. Eligibility is subject to review and approval by Aetna.

**Accelerated Death Benefit Provision**

You may be eligible to receive up to 75% of your life insurance coverage if diagnosed with a terminal or serious medical condition. It's a good idea to consult with your personal tax advisor before making a decision.

**Reductions that apply to Life Insurance**

Your coverage will reduce as you age.

**Your coverage will reduce as follows:**

- At age 65 your coverage will reduce to 65% of the original amount.
- At age 70 your coverage will reduce to 50% of the original amount.
- At age 75 your coverage will reduce to 35% of the original amount.
- At age 80 your coverage will reduce to 20% of the original amount.
- At age 85 your coverage will reduce to 10% of the original amount.
- At age 90 your coverage will reduce to 5% of the original amount.

Life insurance plans/policies are offered and/or underwritten by Aetna Life Insurance Company (Aetna).

**ADP TotalSource Basic Life 10K (# 866285)**
**Your Summary of Group Term Life and AD&PL Benefits**
**AD&PL Features**

A benefit is paid to your surviving spouse/domestic partner or dependent children if you die in an accident.

**Seatbelt/airbag Benefits:** If you die from a motor vehicle accident while wearing a seatbelt, an added benefit is paid. An added benefit is also paid if an airbag inflated.  
**Educational Benefit:** For your spouse and each eligible dependent child under 23.  
**Childcare Benefit:** For each dependent child under 13 to help pay for childcare.  
**Repatriation of Mortal Remains:** If you die in an accident 200 miles or more from home, a benefit will be paid to transport the body to your hometown funeral home.

**Conversion**

If your coverage ends or is reduced, you can convert your Group Term Life policy to a Whole Life Policy.

You may convert your basic coverage into a Whole Life Policy at rates based on your age at time of conversion by paying premiums directly to Aetna. Whole life insurance is generally more expensive than term life insurance so a change in your premium may apply. You will have **60** days to convert your coverage.

**Portability**

If your coverage ends, you can continue coverage as a Term Life Policy

You have an additional option to conversion. You can continue your basic life insurance as a Term Life Policy by paying premiums directly to Aetna. Term insurance is generally less expensive than Whole Life insurance but your rates will increase as you reach higher age bands. You will have **60** days to convert or apply for portability.

**Aetna Life Essentials<sup>®</sup>**

**Legal:** Create a will, living will, health care directive or a durable/financial power of attorney.  
**Financial:** Financial planning to help your beneficiaries maximize their death benefit.  
**Emotional:** Master-level social workers provide emotional support in the event of an advanced illness or disabling condition.  
**Physical:** Save on the cost of gym memberships, fitness equipment, eyeglasses, contact lenses and hearing aids.  
 To learn more visit: [www.aetna.com/aetnalifeessentials](http://www.aetna.com/aetnalifeessentials)

**Funeral Planning and Concierge Services**

Advisory Assistance to help you and your family make decisions on all funeral-related issues. Planning advice and cost-comparison tools available **24/7** by phone and online. Call **1-800-913-8318** or visit [www.everestfuneral.com/aetna](http://www.everestfuneral.com/aetna) (Create an ID by entering your email address and the Enrollment Identification Code: **AETNA0110**)

**Life Claims Center**

Call **1-800-523-5065** for Claim Status Inquiries

Insurance plans contain exclusions and limitations. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Policies may not be available in all states, and rates and benefits may vary by location. Policies are subject to United States economic and trade sanctions. Merrill Edge is available through Merrill Lynch, Pierce, Fenner & Smith Incorporated (MLPF&S), and consists of the Merrill Edge Advisory Center (investment guidance) and self-directed online investing. MLPF&S is a registered broker dealer, Member SIPC, and a wholly owned subsidiary of Bank of America Corporation. The Financial Services Program is independently offered and administered by MLPF&S. Aetna does not provide financial services and makes no representations or warranties as to the quality of the information or services provided by MLPF&S. The Legal Reference<sup>™</sup> program is independently administered by ARAG<sup>®</sup> Services LLC. Aetna has provided its life insurance policyholders with access to Everest Funeral Planning and Concierge Services ("Services"), which are independently administered by Everest Funeral Package, LLC ("Everest"). Access to these Services is not insurance, may be discontinued at any time without notice, and is void where prohibited. Everest is solely responsible for furnishing these Services, and Aetna makes no guarantee or representations as to their quality or suitability. Policy form numbers issued in Idaho and Oklahoma include: GR-9/GR-9N and/or GR-29/GR-29N.



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Civil Rights Coordinator,  
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),  
1-800-648-7817, TTY: 711,  
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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## ADP TotalSource (# 866287)

### Summary of Long-Term Disability (LTD) Benefits

Plan Year: 2017/2018

LTD 50% \$1,000-mo-180

#### Coverage Basics

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**Am I eligible for coverage?**

You qualify if you are an actively-at-work employee working 30 hours or more per week in an eligible class as defined by your worksite employer.

Your coverage will begin on the first day of the month coinciding with or following completion of your worksite employer's waiting period; or the day the worksite employer becomes covered under the plan. If you are not actively-at-work on the effective date, your coverage will not take effect until you return to active work for one full day.

**How much Long-Term Disability does my employer provide?**

Your **employer-paid** plan pays a monthly benefit based on a percentage of your Pre-Disability Earnings\* for a covered disability. You must submit a claim and be approved by Aetna to receive benefits:

\*Generally, Pre-Disability Earnings include your total income before taxes and any deductions for pre-tax contributions. Please consult your Policy Documents available through your employer for additional information, including definition of Pre-Disability Earnings.

| Long-Term Disability | Percentage of monthly income replacement: | Minimum monthly benefit:                                    | Maximum monthly benefit: | Benefits begin after a covered injury or illness: | Benefits end at recovery or: (whichever comes first) |
|----------------------|-------------------------------------------|-------------------------------------------------------------|--------------------------|---------------------------------------------------|------------------------------------------------------|
| Employer-paid Plan   | 50%                                       | \$100 or 10% of gross monthly benefit, whichever is greater | \$1,000                  | 180 days                                          | Age 65 or Social Security Normal Retirement Age**    |

\*\*If your disability occurs at age 62 or later, the maximum age you may receive benefits will be based on a schedule that complies with the Age discrimination in Employment Act (ADEA). Please refer to your Policy Documents for more information.

**Are all types of illnesses and injuries covered?**

Long-Term Disability (LTD) covers injuries and illnesses that are both work-related and non-work-related.

**When am I considered to be Disabled?**

You will be considered disabled for **24** months from the date you last worked if:

- After a significant mental or physical change resulting from an illness or injury, you can't perform the material duties of your own occupation.
- Your earnings are **80%**, or less, of your adjusted Pre-Disability earnings.

After the first **24** months of your disability that monthly benefits are payable, you will be considered disabled on any day that you can't perform the material duties of any reasonable occupation\* due to illness and injury, and your earnings are **60%**, or less, of your adjusted Pre-Disability Earnings.

If your occupation requires a professional license or certification, you will not be considered disabled solely because you lose your license or certification.

\*Any "reasonable occupation" means a job you could be expected to perform satisfactorily in light of your age, education, training, experience, station in life and physical and mental capacity.

**Are there any limitations that apply to Long-Term Disability?**

**Limitations**

You can receive benefit payments for Long-Term Disabilities resulting from mental illness, alcoholism and substance abuse for a total of **24** months for all disability periods during your lifetime. This time period may be extended if you are confined to a hospital.

Disability insurance plans/policies are offered and/or underwritten by Aetna Life Insurance Company (Aetna).

## ADP TotalSource LTD 50% \$1,000-mo-180 (# 866287)

### Your Summary of Long-Term Disability (LTD) Benefits

#### Plan Provisions

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##### Are there any offsets that may reduce Long-Term Disability?

###### Offsets

Your benefits may be reduced if you are receiving income from other sources. See your plan documents for a complete listing. Examples include:

###### Employer sources:

- Any disability or retirement benefit received under a retirement plan
- Disability benefits received from any statutory disability plan
- Payments received from accumulated sick time or salary continuation program related to your current employer

###### Government sources:

- Temporary disability benefits received under any state or federal workers' compensation law
- Benefits from Social Security or similar plan or act (including family benefits)
- Any governmental retirement system earned as a result of working for your current employer

##### Are there any exclusions that apply to Long-Term Disability?

###### Exclusions

You will not receive benefits under certain circumstances. Examples include:

- Your disability results from an intentional self-inflicted injury; or you became injured while committing a criminal act or driving under the influence of alcohol/drugs.
- You are not under the regular care of a doctor when requesting disability benefits.

###### Pre-existing Conditions

Pre-existing Conditions may affect the benefits paid by your Long-Term Disability policy:

- A pre-existing condition is an illness, injury or pregnancy-related condition for which you were diagnosed, received medical treatment, or prescribed medications during the **3** month period before your coverage effective date.
- No benefit will be paid for a disability that occurs during the first **12** months after your coverage effective date that is caused by, or related to, a pre-existing condition.

Please refer to your policy documents for a complete list of income sources that will reduce your benefits, as well as a complete list of exclusions and limitations

##### Is there anything else I should know about my plan?

###### Recurring disabilities

If you return to work and become disabled again from the same illness or injury, it may be considered the same disability. If it is, you will only have to satisfy one elimination period and may be eligible to begin receiving benefits immediately.

###### Partial disabilities

Partial disability benefits allow you to work, earn income and continue receiving benefits so you can receive up to **100%** of your income during the first **12** months of your disability.

###### Survivor Benefit

If you die 180 days or more after you have been qualified for disability benefits we will pay your eligible survivor a lump sum equal to 3 months of your gross disability benefit.

#### Disability Call Center

Call **1-888-200-6790** for Claim Submissions, Status or Questions

This material is for information only. Insurance plans contain exclusions and limitations. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Policies may not be available in all states, and rates and benefits may vary by location. Policies are subject to United States economic and trade sanctions. Policy form numbers issued in Idaho and Oklahoma include: **CR-9/GR-9N** and/or **GR-29/GR-29N**.



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ADP TotalSource®

# Why Enroll in Flexible Spending Accounts (FSAs)?



A more human resource.™

Health Care and Dependent Care FSAs are tax-advantaged accounts that you can use to pay for everyday expenses tax-free.

The tax advantages of the Health Care and Dependent Care FSAs make enrolling in them a good idea every year. FSAs can save you up to 35% (depending on your tax bracket) on health care expenses like deductibles and copays, as well as certain qualifying dependent care expenses like elder care and child day care.

## FSA Features for the 2017–2018 Plan Year

### Health Care FSA debit card

- When you enroll in a Health Care FSA, you'll automatically receive a **Spending Account Card** that works like a bank debit card, providing you immediate reimbursement for your eligible health care expenses and reducing the need to file claims for reimbursement.
- You can still choose to pay for your eligible health care expenses out of your pocket and then fax, mail or submit an online claim reimbursement request along with your receipt for the expense.

**Note:** The debit card isn't available for the Dependent Care FSA.

### Health Care FSA \$500 carryover allowance

- If you enroll in the Health Care FSA, you'll be permitted to carry over up to \$500 of your remaining account balance at the end of the 2017–2018 Plan Year to the following 2018–2019 Plan Year. Any account balance in excess of \$500 will be forfeited. Please note that the carryover allowance doesn't apply to the Dependent Care FSA, so plan accordingly since any remaining balance in the Dependent Care FSA at the end of the Plan Year claim filing period will be forfeited.

### Enroll in a Flexible Spending Account (FSA) today!

1. **ENROLL** in a Health Care and/or Dependent Care FSA during Open Enrollment or when you're newly eligible.
  - For the 2017–2018 Plan Year, you can contribute up to \$2,600 to the Health Care FSA.
  - For the 2017–2018 Plan Year, you can contribute up to \$5,000 (\$2,500 if married filing separately) to the Dependent Care FSA.

2. **CONTRIBUTE** to your FSA(s) over the course of the 2017–2018 Plan Year (via pretax payroll deductions) and build up a balance in your account(s).
3. **USE YOUR DEBIT CARD OR FILE CLAIMS** as you incur eligible health and dependent care expenses. If you sign up for direct deposit, tax-free reimbursements will be deposited right into your checking account.

| Examples of Eligible Expenses                                                                                                                                 |                                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| Health Care FSA                                                                                                                                               | Dependent Care FSA                                                                                                                           |
| Copays, deductibles and coinsurance for health, dental and vision plans                                                                                       | Day care for dependent children under age 13, including before- and after-school care and summer day camp                                    |
| Prescription medications not covered by a health plan and over-the-counter medications (if prescribed by a physician)                                         | Day care for a person of any age whom you claim as a dependent on your federal income tax return, including elder care for dependent parents |
| Dental and vision expenses not covered by a health plan, including glasses, contact lenses, laser vision correction, and orthodontia treatment such as braces | Day care for dependents of any age who are mentally or physically incapable of caring for themselves                                         |

### Other important FSA facts

- For the 2017–2018 Plan Year, highly compensated employees will only be permitted to contribute up to \$2,000 to the Dependent Care FSA.
- The deadline for filing claims incurred during the Plan Year is July 30.
- Over-the-counter medications (except insulin) aren't eligible for reimbursement under the Health Care FSA unless the medication is prescribed by a physician and filled at a pharmacy.
- The **Dependent Care FSA doesn't cover medical expenses** for you or your dependents.
- If more than \$5,000 (\$2,500 if married filing separately) is contributed to the Dependent Care FSA during a single Calendar Year, the excess amount will be included in Box 10 of the Form W-2. It's the participant's responsibility to report any amount over \$5,000 as taxable income on their individual income tax return.



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2017–2018

|                          |                                                            |                                 |                          |
|--------------------------|------------------------------------------------------------|---------------------------------|--------------------------|
| <b>Plan Description:</b> | <b>Health Care Flexible Spending Account (FSA) Summary</b> | <b>Member Services Phone #:</b> | <b>(800) 554-1802</b>    |
| <b>Product:</b>          | <b>Health Care FSA</b>                                     | <b>Website Address:</b>         | <b>MyTotalSource.com</b> |

### Health Care Flexible Spending Accounts

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Plan Year</b>                                              | June 1 – May 31                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Maximum Plan Year contributions <sup>1</sup>                  | \$2,600                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Who is covered?                                               | Employee plus eligible dependents                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| How are contributions processed?                              | Payroll deduction from pretax income                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Balance carryover allowance <sup>2</sup>                      | \$500                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Health Care FSA</b><br>What expenses are eligible?         | <p>The following expenses are eligible for reimbursement if they're not otherwise covered by insurance or any other source:</p> <ul style="list-style-type: none"> <li>■ Medical and dental copayments, deductibles and coinsurance payments</li> <li>■ Medical expenses<sup>3</sup></li> <li>■ Prescription drug expenses</li> <li>■ Over-the-counter medications (if prescribed by a physician)<sup>4</sup></li> <li>■ Dental and orthodontic treatment</li> <li>■ Vision care, including eyeglasses and contact lenses</li> <li>■ Routine physicals, vaccinations and screening tests</li> <li>■ Medical monitoring/testing devices and supplies, including for diabetes</li> </ul> <p><b>PLEASE NOTE:</b> If you choose to enroll in a High Deductible Health Plan (HDHP) and plan on contributing to a Health Savings Account (HSA) at any time during the 2017–2018 Plan Year, you're not eligible to participate in the Health Care FSA. See below for Limited Health Care FSA details.</p>                                                                 |
| <b>Limited Health Care FSA</b><br>What expenses are eligible? | <p>You can participate in the <b>Limited Health Care FSA</b> if you enroll in a qualified High Deductible Health Plan (HDHP) and plan on contributing to a Health Savings Account (HSA) at any time during the 2017–2018 Plan Year. You can use this account to pay for eligible <b>dental and vision</b> expenses with tax-free dollars. <b><u>The Limited Health Care FSA will not reimburse medical expenses.</u></b> Federal regulations don't allow individuals to receive reimbursement for medical expenses tax-free through a Health Care FSA <b>and</b> contribute to an HSA during the same Plan Year.</p> <p>The following expenses are eligible for reimbursement under the Limited Health Care FSA:</p> <ul style="list-style-type: none"> <li>■ Dental and vision copayments, deductibles and coinsurance payments</li> <li>■ Dental and orthodontic treatment</li> <li>■ Vision care, including eyeglasses and contact lenses</li> <li>■ Certain preventive care expenses, such as immunizations and routine examinations and procedures</li> </ul> |

<sup>1</sup> Health Care Reform legislation includes a provision that limits the amount of salary reduction contributions an individual can make to a Health Care Flexible Spending Account (FSA) to \$2,600 per Plan Year. Due to the FSA carryover feature of the Plan, up to \$500 of any unused amount that's remaining in the Health Care FSA from the prior Plan Year will be carried over to the new Plan Year. This carryover amount, if any, may be used to reimburse eligible expenses incurred during the 2017–2018 Plan Year but doesn't count against the maximum contribution limit.

<sup>2</sup> IRS rules require that unused Health Care FSA contribution balances in excess of \$500 be forfeited after the end of the Plan Year filing deadline (i.e., July 30). To minimize the risk of FSA contribution forfeiture, please plan carefully when electing your FSA contributions. For complete details, please refer to the ADP TotalSource<sup>®</sup>, Inc. Health and Welfare Plan Summary Plan Description and Summary of Material Modifications located on My TotalSource<sup>®</sup> at MyTotalSource.com.

<sup>3</sup> If you plan on contributing to a Health Savings Account at any time during the 2017–2018 Plan Year, you can only elect to enroll in the Limited Health Care FSA. Only eligible dental and vision expenses can be submitted for reimbursement under the Limited Health Care FSA. The Limited Health Care FSA won't reimburse medical expenses.

<sup>4</sup> In accordance with Health Care Reform legislation, individuals can't use the ADP TotalSource Health Care FSA for the cost of over-the-counter (OTC) medications unless prescribed by a physician. This rule doesn't apply to reimbursements for the cost of insulin, which are permitted, even if the insulin is purchased without a prescription.



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2017–2018

|                          |                                                               |                                 |                          |
|--------------------------|---------------------------------------------------------------|---------------------------------|--------------------------|
| <b>Plan Description:</b> | <b>Dependent Care Flexible Spending Account (FSA) Summary</b> | <b>Member Services Phone #:</b> | <b>(800) 554-1802</b>    |
| <b>Product:</b>          | <b>Dependent Care FSA</b>                                     | <b>Website Address:</b>         | <b>MyTotalSource.com</b> |

### Dependent Care Flexible Spending Accounts

|                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Plan Year                                   | June 1 – May 31                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Maximum Plan Year contributions             | \$5,000 (\$2,500 if married filing separately) <sup>1</sup> )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| (Highly compensated employees) <sup>2</sup> | \$2,000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Maximum Plan Year contributions             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| How are contributions processed?            | <p>Payroll deduction from pretax income</p> <ul style="list-style-type: none"><li>■ A self-employed individual (SEI) may only participate on a post-tax basis and only if he or she is receiving W-2 wages.</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| What expenses are eligible?                 | <p>Dependent care expenses for dependents<sup>3</sup> under 13 years of age, which you must pay to enable you to work. If you're married, your spouse must also be employed full-time, be a full-time student, or be incapable of self-care.</p> <p>Eligible dependent care expenses include fees charged by:</p> <ul style="list-style-type: none"><li>■ Qualified child care centers and nursery schools</li><li>■ In-home babysitters and nannies</li><li>■ After-school programs that enable employee and spouse to hold gainful employment</li><li>■ Non-nursing care of a dependent age 13 or older who is physically or mentally incapable of self-care</li><li>■ Non-medical care of an elderly dependent whose caregiver spends at least 8 hours a day at the taxpayer's home</li></ul> |

**IMPORTANT NOTE:** Outlined above are examples of eligible expenses. Qualified expenses under the Dependent Care FSA include eligible dependent care costs that you must pay to enable you to work or look for work. **The Dependent Care FSA does NOT cover medical expenses for you or your dependents.** IRS rules require that unused FSA contribution balances be forfeited after the end of the Plan Year filing deadline (i.e., July 30). To minimize the risk of FSA contribution forfeiture, please plan carefully when electing your FSA contributions. For complete details, please refer to the ADP TotalSource<sup>®</sup>, Inc. Health and Welfare Plan Summary Plan Description and Summary of Material Modifications located on My TotalSource<sup>®</sup> at [MyTotalSource.com](http://MyTotalSource.com).

<sup>1</sup> Note that if more than \$5,000 (\$2,500 if married filing separately) is contributed to the Plan during a single Calendar Year, the excess amount will be included in Box 10 of the Form W-2. It's the participant's responsibility to report anything over \$5,000 as taxable income on their individual income tax return.

<sup>2</sup> Highly compensated employees are only permitted to contribute up to \$2,000 per Plan Year to the ADP TotalSource, Inc. Dependent Care FSA. In addition, ADP TotalSource may, at any time before or during the Plan Year (June 1 – May 31), notify a highly compensated employee that he or she must discontinue pretax contributions to the Dependent Care FSA or that he or she must limit such pretax contributions to a particular dollar amount below the \$2,000 maximum if ADP TotalSource determines in its discretion that such action is necessary or advisable in order to satisfy the nondiscrimination requirements applicable to the Dependent Care FSA.

For the 2017–2018 Plan Year, a “highly compensated employee” is defined by the IRS as an individual that (a) owns (or constructively owns) more than 5% of the stock, capital or profits interest of a client company on any day during the Plan Year, or (b) will be paid compensation by ADP TotalSource in excess of \$120,000 annually. Please note that the definition of a highly compensated employee may change for future Plan Years.

<sup>3</sup> Certain IRS rules apply with respect to caregiver/provider eligibility.