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.wespath.org (click on HealthFlex/WebMD, log in and click on HealthFlex Plan Benefits) or call **1-800-851-2201**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call **1-800-851-2201** to request a copy. If this summary and the complete terms of coverage conflict, the complete terms of coverage will control.

Medical coverage is provided by UnitedHealthcare (1-800-901-1939); prescription coverage is provided by OptumRx (1-855-239-8471); and behavioral health benefits are provided by United Behavioral Health (UBH) (1-800-788-5614).

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**If took HealthQuotient:** For participating provider: $3,000 Individual/$6,000 Family For non-participating provider: $6,000 Individual/$12,000 Family **If did not take HealthQuotient:** For participating provider: $3,250 Individual/$6,500 Family For non-participating provider: $6,250 Individual/$12,500 Family	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, preventive care	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $50 Individual/$150 Family for dental benefits, if elected.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.

What is the out-of-pocket limit for this plan?	**For participating provider:** $6,500 Individual/$13,000 Family **For non-participating provider:** $13,000 Individual/$26,000 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, vision expenses, dental expenses, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.uhc.com** or call **1-800-901-1939** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	60% coinsurance after the deductible	80% coinsurance after the deductible	
	Specialist visit	60% coinsurance after the deductible	80% coinsurance after the deductible	
	Preventive care/screening/ immunization	No charge.	80% coinsurance	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)	60% coinsurance after deductible	80% coinsurance after deductible	
	Imaging (CT/PET scans, MRIs)	60% coinsurance after deductible	80% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.wespath.org**; click on HealthFlex/WebMD.	Generic drugs	**Retail (30-day)** 60% coinsurance after the deductible	**Retail (30-day)** 60% coinsurance after the deductible, plus amount exceeding allowed amount	*To maximize plan benefits, **refills for most maintenance medications require use of the OptumRx Home Delivery (mail-order) service or a local Walgreens pharmacy.** Non-preferred name brand drugs do not apply to the out-of-pocket limit. Non-sedating allergy drugs are covered as non-preferred. Specialty drugs may require pre-authorization by contacting OptumRx at **1-855-239-8471**.
		***Mail Order (up to 90-day supply)** 60% coinsurance after the deductible, plus amount exceeding allowed amount		
	Preferred brand drugs	**Retail (30-day)** 60% coinsurance after the deductible, plus amount exceeding allowed amount	**Retail (30-day)** 60% coinsurance after the deductible, plus amount exceeding allowed amount	
		***Mail Order (up to 90-day supply)** 60% coinsurance after the deductible, plus amount exceeding allowed amount		
	Non-preferred brand drugs	**Retail (30-day)** 60% coinsurance after the deductible, plus amount exceeding allowed amount	**Retail (30-day)** 60% coinsurance after the deductible, plus amount exceeding allowed amount	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		***Mail Order (up to 90-day supply)** 60% coinsurance after the deductible, plus amount exceeding allowed amount		
	Specialty drugs	60% coinsurance after the deductible, plus amount exceeding allowed amount	60% coinsurance after the deductible, plus amount exceeding allowed amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	60% coinsurance after deductible	80% coinsurance after deductible	
	Physician/surgeon fees	60% coinsurance after deductible	80% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	60% coinsurance after deductible	60% coinsurance after deductible	Notification required within 48 hours if admitted; copayment not applicable if admitted. Costs assume true emergency.
	Emergency medical transportation	60% coinsurance after deductible	60% coinsurance after deductible	
	Urgent care	60% coinsurance after deductible	60% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	60% coinsurance after deductible	$200 copayment and 80% coinsurance after deductible	Pre-notification required. Verify with physician.
	Physician/surgeon fees	60% coinsurance after deductible	$200 copayment and 80% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	60% coinsurance after deductible	60% coinsurance after deductible for office visits*	*80% coinsurance after deductible for all services other than office visits Eligible out-of-pocket expenses for the behavioral health, pharmacy and medical plans count toward the out-of-pocket limit. Refer to page 1 or 2 for the applicable out-of-pocket limit.
	Inpatient services	60% coinsurance after deductible	$200 copayment and 80% coinsurance after deductible	
If you are pregnant	Office visits	100% for prenatal care (except ultrasounds) 60% coinsurance after deductible for ultrasounds and subsequent eligible physician charges	80% coinsurance after deductible	Cost-sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.) Initial visit to confirm pregnancy subject to regular office visit co-payment or coinsurance.
	Childbirth/delivery professional services	60% coinsurance after deductible	80% coinsurance after deductible	
	Childbirth/delivery facility services	60% coinsurance after deductible	80% coinsurance after deductible	Pre-notification required. Verify with physician.
If you need help recovering or have other special health needs	Home health care	60% coinsurance after deductible	80% coinsurance after deductible	Coverage is limited to 60 visits per calendar year. Pre-notification required. Verify with physician.
	Rehabilitation services	60% coinsurance after deductible	80% coinsurance after deductible	
	Habilitation services	60% coinsurance after deductible	80% coinsurance after deductible	
	Skilled nursing care	60% coinsurance after deductible	80% coinsurance after deductible	Coverage is limited to 120 days per calendar year. Pre-notification required. Verify with physician.
	Durable medical equipment	60% coinsurance after deductible	80% coinsurance after deductible	Coverage for wigs is limited to 5 per lifetime.
	Hospice services	60% coinsurance after deductible	80% coinsurance after deductible	Pre-notification required. Verify with physician.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	**Exam Core:** $20 copayment **Full Vision:** $20 copayment **Premier Vision:** $20 copayment	**Exam Core:** Exam fee exceeding $45 **Full Vision:** Exam fee exceeding $45 **Premier Vision:** Exam fee exceeding $45	**Exam Core:** Includes one exam every year. **Full Vision:** Includes one exam every year. **Premier Vision:** Includes one exam every year.
	Children's glasses	**Exam Core:** Not Covered **Full Service:** $20 copayment for frames and/or lenses; for frames, 80% of cost in excess of $150 **Premier Vision:** $20 copayment for frames and lenses; for frames, 80% of cost in excess of $200	**Exam Core:** Not Covered **Full Service:** Cost of frames in excess of $70. Cost of single vision lenses over $30; line bifocal lenses over $50; lined trifocal lenses over $65. **Premier Vision:** Cost of frames in excess of $70. Cost of single vision lenses over $30; line bifocal lenses over $50; lined trifocal lenses over $65.	**Exam Core:** None **Full Service:** Includes one pair of frames every other year and lenses every year. **Premier Vision:** Includes one pair of frames and lenses every year.
	Children's dental check-up	**Dental PPO:** No charge **Passive PPO 1000:** No charge **Passive PPO 2000:** No charge	**Dental PPO:** No charge **Passive PPO 1000:** No charge **Passive PPO 2000:** No charge	**Dental PPO:** Annual coverage is limited to $2,000 maximum (in-network) and $1,000 (out-of-network) for all covered services **Passive PPO 1000:** Coverage is limited to $1,000 annual maximum for all covered services. **Passive PPO 2000:** Coverage is limited to $2,000 annual maximum for all covered services.

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.)

- Cosmetic Surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.

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

- Acupuncture
- Bariatric surgery (if meet eligibility)
- Chiropractic care
- Dental care (Adult), if elected
- Hearing Aids
- Infertility Treatment
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Your Rights to Continue Coverage: You may be eligible for continuation coverage through HealthFlex. Contact us at 1-800-851-2201 for more information. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-800-901-1939.

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 the 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 1-800-851-2201.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-851-2201.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-851-2201.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$3,000
Specialist *coinsurance*	60%
Hospital (facility) *coinsurance*	60%
Other *coinsurance*	60%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,300
Copayments	$0
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,860**

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

The plan's overall deductible	$3,000
Specialist *coinsurance*	60%
Hospital (facility) *coinsurance*	60%
Other *coinsurance*	60%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,300
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4,200**

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

The plan's overall deductible	$3,000
Specialist *coinsurance*	60%
Hospital (facility) *coinsurance*	60%
Other *coinsurance*	60%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

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

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: **1-800-851-2201**.

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