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, call (814) 870-3747 or visit www.myuhc.com. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call (814) 870-3747 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 individual/$500 family in-network $500 individual/$1,000 family out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Primary care visits, specialist visits, preventive services, urgent care, outpatient mental health, outpatient substance use disorder, prescription drugs and telemedicine that are in-network. Emergency room care in-network or out-of-network.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,000 individual/$2,000 family in-network out-of-pocket limit for deductibles, coinsurance and copayments on everything but prescription drugs. $2,000 individual/$4,000 family out-of-network. A separate out-of-pocket limit of $5,600 individual/$11,200 family applies for prescription drug coinsurance and copayments.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-888-651-7322 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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	$20/visit	30% coinsurance	Deductible does not apply in-network.
	Specialist visit	$35/visit	30% coinsurance	Deductible does not apply in-network.
	Preventive care/screening/ immunization	No charge.	30% 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)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myuhc.com or by calling 1-888-651-7322	Generic drugs (Tier 1)	20% coinsurance	Not covered	$10 minimum/$50 maximum per 30 day supply from retail pharmacy; $20 minimum/ $100 maximum per 90 day supply from mail order pharmacy. Deductible does not apply.
	Preferred brand drugs (Tier 2)	20% coinsurance	Not covered	$10 minimum/$50 maximum per 30 day supply from retail pharmacy; $20 minimum/ $100 maximum per 90 day supply from mail order pharmacy. Deductible does not apply.
	Non-preferred brand drugs (Tier 3)	50% coinsurance	Not covered	$10 minimum/$50 maximum per 30 day supply from retail pharmacy; $20 minimum/ $100 maximum per 90 day supply from mail

* For more information about limitations and exceptions, see the plan document at ERIEweb - Info Center - Benefits Info - Benefits Summary Plan Descriptions.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				order pharmacy. Deductible does not apply.
	Specialty drugs (Tier 4)	50% coinsurance	Not covered	$10 minimum/$50 maximum per 30 day supply. Deductible does not apply. Must be purchased through a designated pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$100/visit	$100/visit	Deductible does not apply. Copayment waived if admitted as an inpatient.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Out-of-network subject to network deductible.
	Urgent care	$40/visit	30% coinsurance	Deductible does not apply in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20/visit	30% coinsurance	Deductible does not apply in-network.
	Inpatient services	10% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	$20/visit	30% coinsurance	Deductible does not apply in-network.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have	Home health care	10% coinsurance	30% coinsurance	None
	Rehabilitation services	10% coinsurance	30% coinsurance	Combined in-network and out-of-network:

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs				35 physical therapy visits per calendar year; 25 speech, occupational therapy and manipulative treatment (chiropractic) visits per calendar year.
	Habilitation services	Not covered	Not covered	Some Habilitation Services are covered.
	Skilled nursing care	10% coinsurance	30% coinsurance	None
	Durable medical equipment	10% coinsurance	30% coinsurance	None
	Hospice services	10% coinsurance	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

- Children's eye exams
- Cosmetic Surgery
- Dental Care (Adult)
- Children's glasses
- Children's dental check-ups
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Habilitation services (some covered)
- Routine eye care (Adult)
- Travel immunizations
- Weight loss programs (two programs are covered)

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Limited to $3,000 per hearing impaired ear every 3 calendar years)
- Infertility treatment (When provided by or under the direction of a physician)
- Private-duty nursing (Provided on an outpatient basis)
- Routine foot care (When needed for severe systemic disease)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform. 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.

* For more information about limitations and exceptions, see the plan document at ERIEweb - Info Center - Benefits Info - Benefits Summary Plan Descriptions.

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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Erie Insurance Benefits Operations Section using the HR Helpline at (814) 870-3747 or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 (814) 870-3747.

*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	**$250**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$250
Copayments	$0
Coinsurance	$750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

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

The plan's overall deductible	**$250**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$870**

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

The plan's overall deductible	**$250**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$650**

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