




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](http://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 <a href="#">deductible</a> ?	\$250 individual/\$500 family in- <a href="#">network</a> \$500 individual/\$1,000 family out-of- <a href="#">network</a>	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Primary care visits, <a href="#">specialist</a> visits, <a href="#">preventive services</a> , <a href="#">urgent care</a> , outpatient mental health visits, outpatient substance use disorder visits, <a href="#">prescription drugs</a> and telemedicine that are in- <a href="#">network</a> . <a href="#">Emergency room care</a> in- <a href="#">network</a> or out-of- <a href="#">network</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$1,000 individual/\$2,000 family in- <a href="#">network out-of-pocket limit</a> for <a href="#">deductibles</a> , <a href="#">coinsurance</a> and <a href="#">copayments</a> on everything but <a href="#">prescription drugs</a> . \$2,000 individual/\$4,000 family out-of- <a href="#">network</a> . A separate <a href="#">out-of-pocket limit</a> of \$5,600 individual/\$11,200 family applies for <a href="#">prescription drug coinsurance</a> and <a href="#">copayments</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges and health care this <a href="#">plan</a> doesn't	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

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

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20/visit	30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply in- <a href="#">network</a> .
	<a href="#">Specialist</a> visit	\$35/visit	30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply in- <a href="#">network</a> .
	<a href="#">Preventive care/screening/immunization</a>	No charge.	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling 1-888-651-7322	Generic drugs (Tier 1)	20% <a href="#">coinsurance</a>	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. <a href="#">Deductible</a> does not apply.
	Preferred brand drugs (Tier 2)	20% <a href="#">coinsurance</a>	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. <a href="#">Deductible</a> does not apply.
	Non-preferred brand drugs (Tier 3)	50% <a href="#">coinsurance</a>	Not covered	\$10 minimum/\$50 maximum per 30 day supply from retail pharmacy; \$20 minimum/

\* For more information about limitations and exceptions, see the plan document at ERIEweb - Info Center - Benefits Info - Benefits Summary Plan Descriptions. **2 of 6**

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)	
				\$100 maximum per 90 day supply from mail order pharmacy. <a href="#">Deductible</a> does not apply.
	<a href="#">Specialty drugs</a> (Tier 4)	50% <a href="#">coinsurance</a>	Not covered	\$10 minimum/\$50 maximum per 30 day supply. <a href="#">Deductible</a> does not apply. Must be purchased through a designated pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100/visit	\$100/visit	<a href="#">Deductible</a> does not apply. <a href="#">Copayment</a> waived if admitted as an inpatient.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Out-of- <a href="#">network</a> subject to <a href="#">network deductible</a> .
	<a href="#">Urgent care</a>	\$40/visit	30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply in- <a href="#">network</a> .
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$20 copayment for an in-network office visit.
	Inpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	\$20/visit	30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply in- <a href="#">network</a> .
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None

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)	
recovering or have other special health needs	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Combined in- <a href="#">network</a> and out-of- <a href="#">network</a> : 35 physical therapy visits per calendar year; 25 speech, occupational therapy and manipulative treatment (chiropractic) visits per calendar year.
	<a href="#">Habilitation services</a>	Not covered	Not covered	Some <a href="#">Habilitation Services</a> are covered.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>Children's eye exams</li> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Children's glasses</li> <li>Children's dental check-ups</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li><a href="#">Habilitation services</a> (some covered)</li> <li>Routine eye care (Adult)</li> <li>Travel immunizations</li> <li>Weight loss programs (two programs are covered)</li> </ul>	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)			
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids (Limited to \$3,000 per hearing impaired ear every 3 calendar years)</li> <li>Infertility treatment (When provided by or under the direction of a physician)</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing (Provided on an outpatient basis)</li> <li>Routine foot care (When needed for severe systemic disease)</li> </ul>	

**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](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 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$750
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,060</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$400
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$870</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$650</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.