




**Valero Services, Inc.**  
**Copay/\$500 Ded Ret Choice Plus**



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.valero.amwins.com](http://www.valero.amwins.com) or call 1-844-634-1235. 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-844-634-1235 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	In- <u>Network</u> *: \$500 Individual / \$1,000 Family Out-of- <u>Network</u> *: \$1,000 Individual / \$2,000 Family per calendar year. Does not apply to copays, pharmacy drugs, and services listed below as “No Charge”. * <u>Deductibles</u> cross-apply	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 other family members 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 <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive Care</u> and primary care services with <u>copay</u> are covered before you meet your <u>deductible</u> .	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 <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other <u>deductibles</u> for specific services?</b>	Yes, Preferred, Non-Preferred Brand & Specialty <u>Prescription Drugs</u> – In- <u>Network</u> /Out-of- <u>Network</u> : \$100 Individual / \$200 Family	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Medical- In- <u>Network</u> *: \$2,500 Individual / \$5,000 Family Out-of- <u>Network</u> *: \$5,000 Individual / \$10,000 Family per calendar year <u>Prescription Drugs</u> - In- <u>Network</u> : \$4,100 Individual / \$8,200 Family; *Out-of-pockets cross-apply	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

Important Questions	Answers	Why This Matters:
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain <u>prior authorization</u> for services. <u>Copays</u> for certain Specialty <u>prescription drugs</u> considered non-essential health benefits under the coverage. The <u>copays</u> for these drugs (though manufacturer copay assistance programs may support some fills at no remaining cost to you) will not apply toward satisfying your <u>out-of-pocket</u> limit or any applicable <u>deductible</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-844-634-1235 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No	You can see the <u>specialist</u> 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		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	40% <u>coinsurance</u>	Virtual visit- In <u>network</u> \$15 <u>copay</u> per visit, by a Designated Virtual <u>Network Provider</u> . No virtual visit coverage for out of <u>network</u> .
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u> <u>deductible</u> does not apply	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> for sleep studies or \$200 penalty.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	Retail: \$10 <u>copay/prescription</u> Retail90 & Home Delivery: \$25 <u>copay/prescription</u>	Applicable copay and difference between actual drug cost and the in-network contracted rate	Coverage is limited up to a 30-day supply (retail), 84-90 day supply (Retail90) and up to a 90-day supply (Home Delivery).
	Preferred brand drugs	Retail: \$30 <u>copay/prescription</u> Retail90 & Home Delivery: \$75 <u>copay/prescription</u>	Applicable copay and difference between actual drug cost and the in-network contracted rate	Coverage is subject to Preferred <u>Formulary</u> drug list. Some prescriptions may be subject to a Maintenance Medication Retail90 program, Step Therapy Program, <u>Prior Authorization</u> and/or quantity limits.
	Non-preferred brand drugs	Retail: \$60 <u>copay/prescription</u> Retail90 & Home Delivery: \$150 <u>copay/prescription</u>	Applicable copay and difference between actual drug cost and the in-network contracted rate	
	<u>Specialty drugs</u>	Generic \$25 <u>copay/prescription</u> Non-preferred Brand \$150 <u>copay/prescription</u>	Not covered	<u>Specialty drugs</u> covered only when obtained through Accredo Pharmacy. For more information call 1-800-922-8279. Copays for certain specialty prescription drugs considered non-essential health benefits under the coverage bypass your out-of-pocket limit. Please see “Important Questions” regarding the coverage’s out-of-pocket limit.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> or \$200 penalty applies.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit	\$200 <u>copay</u> /visit	If admitted <u>Prior Authorization</u> required within 48 hours out-of- <u>network</u> or \$200 penalty. No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$100 <u>copay</u> /visit	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> or \$200 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay</u> /visit	40% <u>coinsurance</u>	<u>Prior Authorization</u> required for certain services out-of- <u>network</u> or \$200 penalty applies.  Partial <u>Hospitalization</u> /Intensive Outpatient Treatment In <u>Network</u> 80% after plan <u>deductible</u> and out of <u>network</u> 60% after plan <u>deductible</u> .  Intensive Behavioral Therapy (ABA) In <u>Network</u> 80% no <u>deductible</u> and out of <u>network</u> 60% no <u>deductible</u> .
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> or \$200 penalty.

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 are pregnant	Office visits	\$25 <u>copay</u> /initial visit only	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out of <u>network</u> for Inpatient stays that exceed normal 48 hours for vaginal delivery or 96 hours for cesarean or \$200 penalty. <u>Routine prenatal care is covered at no charge</u> . Depending on the type of service, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound)
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 70 visits per calendar year for <u>Home Health Care</u> . <u>Prior Authorization</u> required out-of- <u>network</u> for <u>Home Health Care</u> for certain services or \$200 penalty applies.
	<u>Rehabilitation services</u>	\$35 <u>copay</u> /visit; Outpatient facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Occupational Therapy, Physical Therapy, Speech Therapy, Cardiac and Pulmonary Rehab. Review for medical necessity is required following the 30th visit (Review starts at visit 31).
	<u>Habilitation services</u>	\$35 <u>copay</u> /visit; Outpatient facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Refer to <u>Rehabilitation services</u>
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 days per calendar year combined In/Out-of- <u>network</u> . <u>Prior Authorization</u> required out-of- <u>network</u> or \$200 penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> for DME over \$1,000 or \$200 penalty.

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)	
	Hospice services	20% coinsurance	40% coinsurance	Prior Authorization required out-of-network before admission for an inpatient stay in a hospice facility or \$200 penalty.
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.)		
<ul style="list-style-type: none"> <li>Adult routine vision exam (i.e. refraction)</li> <li>Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental Care (Adult)</li> <li>Hearing aids (Adult)</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan 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 (Pediatric)</li> <li>Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://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: 1-844-634-1235 or visit [www.myuhc.com](http://www.myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

**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 1-844-634-1235.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-634-1235.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-634-1235.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-844-634-1235 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-634-1235.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-844-634-1235.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-844-634-1235.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-844-634-1235.

—————*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)

■ <u>The plan's overall deductible</u>	\$500
■ <u>Specialist copayment</u>	\$35
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*pre-natal 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:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,000
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,560</b>

### Managing Joe's type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$500
■ <u>Specialist copayment</u>	\$35
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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*)

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

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$200
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,220</b>

### Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$500
■ <u>Specialist copayment</u>	\$35
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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*)

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

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,000</b>

\* Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.