



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 1-888-876-7098 or visit welcometouhc.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 www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$750 Individual / \$1,500 Family Out-of-Network: \$1,500 Individual / \$3,000 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.
Are there services covered before you meet your deductible?	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 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?	Network: \$3,500 Individual / \$7,000 Family Out-of-Network: \$7,000 Individual / \$14,000 Family Per calendar year.	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, 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.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call 1-888-876-7098 for a list of network providers.	You pay the least if you use a provider in the Designated Network. You pay more if you use a provider in the 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Designated <u>Network</u> : \$25 <u>copay</u> per visit, <u>deductible</u> does not apply. <u>Network</u> : \$45 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	Virtual visits - No Charge by a Designated Virtual <u>Network Provider</u> . No virtual coverage <u>out-of-network</u> If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Specialist</u> visit	Designated <u>Network</u> : \$55 <u>copay</u> per visit, <u>deductible</u> does not apply. <u>Network</u> : \$70 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. No coverage <u>out-of-network</u>
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Free Standing/Office: 15% <u>coinsurance</u> Hospital: 25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: 15% <u>coinsurance</u> Hospital: 25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at welcometouhc.com</p>	Tier 1 – Your Lowest Cost Option	<p>Retail: \$4 <u>copay, deductible</u> does not apply. Mail-Order: \$10 <u>copay, deductible</u> does not apply.</p> <p>Retail: 25% <u>coinsurance</u> with a \$18 copay maximum, <u>deductible</u> does not apply. Mail-Order: 25% <u>coinsurance</u> with a \$42 copay maximum, <u>deductible</u> does not apply</p>	Retail: Not Covered	<p><u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy You may need to obtain certain drugs, including certain <u>specialty drugs</u>, from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. If you use an <u>out-of-network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u>. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u>. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable <u>copay</u> and/or <u>coinsurance</u> may be applied. Pharmacy <u>out-of-pocket limit</u>: \$1,500 Ind/ \$3,000 Fam.</p>
	Tier 2 – Your Mid-Range Cost Option	<p>Retail: 25% coinsurance with a \$80 copay maximum, <u>deductible</u> does not apply. Mail-Order: 25% coinsurance with a \$160 copay maximum, <u>deductible</u> does not apply..</p>	Retail: Not Covered	
	Tier 3 – Your Mid-Range Cost Option	<p>Retail: 25% <u>coinsurance</u> with a \$200 copay maximum, <u>deductible</u> does not apply. Mail-Order: 25% <u>coinsurance</u> with a \$500 copay maximum, <u>deductible</u> does not apply</p>	Retail: Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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)	Ambulatory Surgical Center/Office: 15% <u>coinsurance</u> Hospital: 25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	15% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> per visit, <u>deductible</u> does not apply.	\$250 <u>copay</u> per visit, <u>deductible</u> does not apply.	None
	<u>Emergency medical Transportation</u>	15% <u>coinsurance</u>	*15% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<u>Urgent care</u>	\$75 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	If you receive services in addition to <u>Urgent care</u> visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	15% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	<u>Network</u> Partial hospitalization/intensive outpatient treatment: \$25 <u>copay</u> per visit, <u>deductible</u> does not apply. <u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Inpatient services	15% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . See your policy or <u>plan</u> document for additional information about EAP benefits.
If you are pregnant	Office visits	No Charge	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	15% <u>coinsurance</u>	50% <u>coinsurance</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.)

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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)	
	Childbirth/delivery facility services	15% <u>coinsurance</u>	50% <u>coinsurance</u>	Inpatient preauthorization applies <u>out-of-network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of <u>allowed amount</u> .
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 100 visits per calendar year. <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<u>Rehabilitation services</u>	Physical Therapy: \$40 <u>copay</u> per visit, <u>deductible</u> does not apply All other therapies: \$55 <u>copay</u> per visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	Limits per calendar year: Physical/Occupational/ Speech and Pulmonary: combined limit 60 visits; Cardiac: 36 visits.
	<u>Habilitative services</u>	Physical Therapy: \$40 <u>copay</u> per visit, <u>deductible</u> does not apply All other therapies: \$55 <u>copay</u> per visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 90 days per calendar year (combined with inpatient rehabilitation). <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for DME over \$1,000 or no coverage.
	<u>Hospice services</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of <u>allowed amount</u> .
	If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered
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 Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care• Glasses	<ul style="list-style-type: none">• Long-term care• Non-emergency care when travelling outside - the U.S.	<ul style="list-style-type: none">• Private duty nursing• Routine eye care• Routine foot care – Except as covered for Diabetes• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none">• Bariatric surgery• Chiropractic (Manipulative care) – 24 visits per calendar year	<ul style="list-style-type: none">• Hearing aids• Infertility treatment	

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, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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 Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact 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 1-888-876-7098.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-876-7098.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-876-7098.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-876-7098.

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

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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.

<p>Peg is Having a Baby (9 months of in-<u>network</u> pre-natal care and a hospital delivery)</p>	<p>Managing Joe's type 2 Diabetes (a year of routine in-<u>network</u> care of a well-controlled condition)</p>	<p>Mia's Simple Fracture (in-<u>network</u> emergency room visit and follow up care)</p>
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|---|---|---|
| <ul style="list-style-type: none"> ■ The <u>plan's</u> overall <u>deductible</u> \$750 ■ <u>Specialist copay</u> \$70 ■ <u>Hospital (facility) coinsurance</u> 15% ■ <u>Other coinsurance</u> 15% | <ul style="list-style-type: none"> ■ The <u>plan's</u> overall <u>deductible</u> \$750 ■ <u>Specialist copay</u> \$70 ■ <u>Hospital (facility) coinsurance</u> 15% ■ <u>Other coinsurance</u> 15% | <ul style="list-style-type: none"> ■ The <u>plan's</u> overall <u>deductible</u> \$750 ■ <u>Specialist copay</u> \$70 ■ <u>Hospital (facility) coinsurance</u> 15% ■ <u>Other coinsurance</u> 15% |
|---|---|---|

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*)

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*)

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	\$12,700
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Total Example Cost	\$5,600
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Total Example Cost	\$2,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,600
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,420

In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$1,800
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,050

In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,330

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

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](mailto: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 LƯU 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 thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

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PAUNA\VA: Kungnagsasalita 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).

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ATANSYON: Si wpale **Kreyol ayisyen (Haitian Creole)**, ou kapab benefisyè sevis ki gratis pou ede w nan lang paw. 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).

U\VAGA: Jezeli m6, viz po **polsku (Polish)**, udost pnilismy darmowe uslugi tlumacza. Prosimy zadzwonic pod bezplatny numer podany w niniejszym Zesta, vieniu s, viadczen i refundacji (Summary of Benefits and Coverage, SBC).

ATEN<;AO: Se voce fala **portugues (Portuguese)**, contate o servico de assistencia de idiomas gratuito. Ligue para o numero gratuito listado neste Resumo de Beneficios 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. Bitterufen Sie die in dieser Zusammenfassung der Leistungen und Kostenubemahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

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CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais!us pub dawbrau koj. Thov hu rau tus xov tooj hu dawb teevmuaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

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PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawatnga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti unegna daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

Dff BAA'A.KONINIZIN **Dine (Navajo)** bizaad bee yanilti'go, saad bee aka'anida'awo'igii, t'aa jiik'eh, bee na'ah66t'i'. T'aa shqqdi Naaltsoos Bee 'Aa'ahayani d66 Bee 'Ak'e'asti' Bee Baa Hane'i (Summary of Benefits and Coverage, SBC) biyi' t'aa jiik'ehgo beesh bee hane'i bika'igii bee hodiilnih.

OGO.V: 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).