**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 1-800-603-4190.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?** | **$0** | See the Common Medical Events Chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | No. | See the Common Medical Events Chart below for your costs for services this plan covers. |
| **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: **$1,100 Individual / $3,600 Family**<br>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. | 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 **1-800-603-4190** 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 | $10 copay per visit, deductible does not apply. | Not Covered | Virtual visits - No Charge by a Designated Virtual Network Provider. Office Visit cost share applies to any other Telehealth service based on provider type. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. |
| | Specialist visit | $10 copay per visit, deductible does not apply. | Not Covered | If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. |
| | Preventive care/screening/ immunization | No Charge | Not Covered | 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) | No Charge | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | No Charge | Not Covered | None |
| **If you need drugs to treat your illness or condition** | Tier 1 – Your Lowest Cost Option | Not Covered | Not Covered | No coverage for prescription drugs with UnitedHealthcare |
| | Tier 2 – Your Mid-Range Cost Option | Not Covered | Not Covered | |
| | Tier 3 – Your Mid-Range Cost Option | Not Covered | Not Covered | |
| | Tier 4 – Your Highest Cost Option | Not Applicable | Not Applicable | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $25 copay/service, deductible does not apply. | Not Covered | None |
| | Physician/surgeon fees | No Charge | Not Covered | None |
| | Emergency room care | $50 copay per visit, deductible does not apply. | $50 copay per visit, deductible does not apply. | 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) | |
| **If you need immediate medical attention** | Emergency medical transportation | No Charge | No Charge | None |
| | Urgent care | $15 copay per visit, deductible does not apply. | Not Covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | Not Covered | None |
| | Physician/surgeon fees | No Charge | Not Covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $10 copay per visit, deductible does not apply. | Not Covered | Network Partial hospitalization/intensive outpatient treatment: $10 copay per visit, deductible does not apply. |
| | Inpatient services | No Charge | Not Covered | None |
| **If you are pregnant** | Office visits | $10 copay initial visit No Charge after initial visit | Not Covered | Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | No Charge | Not Covered | |
| | Childbirth/delivery facility services | No Charge | Not Covered | None |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | Not Covered | Limited to 60 visits per calendar year. |
| | Rehabilitation services | $10 copay per visit, deductible does not apply. | Not Covered | Limits per calendar year: Physical/Occupational/ Speech: combined limit 60 visits; Cardiac: Unlimited; Pulmonary: Unlimited. |
| | Habilitative services | $10 copay per visit, deductible does not apply. | Not Covered | Services are provided under and limits are combined with Rehabilitation Services above. Benefits are limited to children under age 19 for the treatment of a child with a cogenital or genetic birth defect to enhance a child's ability to function except for early intervention and school services. |
| | Skilled nursing care | No Charge | Not Covered | Limited to 60 days per calendar year (combined with inpatient rehabilitation). |
| | Durable medical equipment | No Charge | Not Covered | Covers 1 per type of DME (including repair/replacement) every 3 years. |

| 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 | No Charge | Not Covered | Benefits are limited to 360 days during the entire period of time a Covered person is covered under the plan. Pre-notification is required |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | No coverage for Children's eye exams. |
| | 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care
- Glasses
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Prescription drugs
- 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 plan document.)**

- Acupuncture - 24 visits per calendar year
- Bariatric surgery
- Chiropractic (Manipulative care) - 24 visits per calendar year
- Hearing aids – $3,000 per 36 months
- Infertility treatment - limited to $30,000 per lifetime

**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.

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 1-800-603-4190.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-603-4190.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-603-4190.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-603-4190 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-603-4190.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-603-4190.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-603-4190.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-603-4190.

***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 | $0 |
| Specialist copay | $10 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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)*

| | |
|---|---|
| **Total Example Cost** | **$12,700** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $100 |
| **The total Peg would pay is** | **$100** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copay | $10 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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 | $0 |
| Copayments | $60 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $6,000 |
| **The total Joe would pay is** | **$6,060** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copay | $10 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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 | $0 |
| Copayments | $100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$100** |

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