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 1-833-273-8750.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: **$1,700** Individual / **$3,400** Family Out-of-Network: **$3,050** Individual / **$6,100** 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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is 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: **$2,500** Individual / **$5,000** Family Out-of-Network: **$5,000** Individual / **$10,000** 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, the overall family out-of-pocket limit must be 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 **1-833-273-8750** 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% coinsurance	30% coinsurance	Virtual visits - 0% coinsurance by a Designated Virtual Network Provider. Office Visit cost share applies to any other Telehealth service based on provider type. No virtual coverage out-of-network
	Specialist visit	10% coinsurance	30% coinsurance	None
	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	Preauthorization is required out-of-network for certain services or a $1,000 penalty applies.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Preauthorization is required out-of-network or a $1,000 penalty applies.

* 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 need drugs to treat your illness or condition	Tier 1 – Your Lowest Cost Option	$15 copay/30-day supply (Retail) $37.50 copay/90-day supply (retail) $0 copay/90-day supply (if filled through Express Scripts mail Order)	$15 copay/30-day supply (Retail)** $37.50 copay/90-day supply (retail or mail order)**	**Prescription Drugs Covered through Express Scripts** Covers Up to a 90 day supply at retail or mail order (higher copay applies to 31-90 day supply). Under the UHC CDHP, copays apply after the deductible has been met. Additional Prescription Drug Programs: •Certain prescription drugs identified by the Affordable Care Act as preventive care are covered in full and not subject to the deductible or copay amounts indicated. •Generics Preferred: You pay the difference in cost if you or your doctor request a brand-name drug instead of its generic equivalent. This amount will not accumulate toward the out of pocket limit. •Step Therapy Program: Your plan uses utilization management (UM) programs that require you try one or more cost effective drugs before certain brand-name drugs will be covered. •Drug Quantity Management Program: The plan limits the quantity of certain drugs covered by the plan. •Encircle Rx: Your plan uses utilization management programs that require prior authorization and participation in the Omada program for certain prescription drugs with a GLP-1 classification to be covered. Tier 4 drugs requires use of Express Scripts Specialty Pharmacy after initial Rx fill ** If you use an out-of-network pharmacy, you will have to pay for the prescription in full and submit a claim to **Express Scripts** for reimbursement of your out of pocket costs less the applicable copay.
	Tier 2 – Your Mid-Range Cost Option	$35 copay/30-day supply (Retail) $87.50 copay/90-day supply (Retail or Mail Order)	$35 copay/30-day supply (Retail)** $87.50 copay/90-day supply (Retail or Mail Order)**	
	Tier 3 – Your Mid-Range Cost Option	$60 copay/30-day supply (Retail) $150 copay/90-day supply (Retail or Mail Order)	$60 copay/30-day supply (Retail)** $150 copay/90-day supply (Retail or Mail Order)**	
	Tier 4 – Your Highest Cost Option	Same copays as above	Same copays as above	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Preauthorization is required out-of-network for certain services or a $1,000 penalty applies.

* 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 need immediate medical attention	Emergency room care	10% coinsurance	*10% coinsurance	*Network deductible applies
	Emergency medical transportation	10% coinsurance	*10% coinsurance	*Network deductible applies
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization is required out-of-network or a $1,000 penalty applies.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 10% coinsurance Preauthorization is required out-of-network for certain services or a $1,000 penalty applies. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization is required out-of-network or a $1,000 penalty applies. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office visits	10% coinsurance for initial visit to confirm pregnancy, then no charge	30% coinsurance	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	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	Inpatient preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or a $1,000 penalty applies.

If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Limited to 200 visits per calendar year and 3 visit per day. Preauthorization is required out-of-network or a $1,000 penalty 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)	
	Rehabilitation services	10% coinsurance	30% coinsurance	Limits per calendar year: Physical, Speech, Occupational, Pulmonary: 60 visits each; Cardiac: Unlimited visits Preauthorization required out-of-network for certain services or a $1,000 penalty applies.
	Habilitative services	10% coinsurance	30% coinsurance	Limits per calendar year: Physical, Speech, Occupational: Unlimited Preauthorization required out-of-network for certain services or a $1,000 penalty applies.
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 120 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network or a $1,000 penalty applies.
	Durable medical equipment	10% coinsurance	*10% coinsurance	*Network deductible applies Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or a $1,000 penalty applies.
	Hospice services	10% coinsurance	30% coinsurance	None
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.

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

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 • 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 – 30 visits per calendar year • Bariatric surgery	• Chiropractic (Manipulative care) – 30 visits per calendar year • Hearing aids – 1 pair every 3 years	• Infertility treatment- administered through WinFertility • Non-emergency care when travelling outside - the U.S.

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 1-833-273-8750.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-833-273-8750.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-273-8750.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-833-273-8750 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-273-8750.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-273-8750.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-273-8750.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-833-273-8750.

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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,700**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$1,700
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	**$1,700**
Specialist coinsurance	**10%**
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	$1,050
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,050**

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

The plan's overall deductible	**$1,700**
Specialist coinsurance	**10%**
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	$1,700
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

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