



 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 1-866-633-2446 or visit [welcometouhc.com](http://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/](http://www.healthcare.gov/sbc-glossary/) or call 1-866-487-2365 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| <p>What is the overall <u>deductible</u>?</p>                             | <p><u>Network</u>: \$275 Individual / \$550 Family<br/> <u>Non-Network</u>: \$550 Individual / \$1,100 Family<br/>                     Per calendar year.</p>  | <p>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>. Deductible resets January 1.</p>   |
| <p>Are there services covered before you meet your <u>deductible</u>?</p> | <p>Yes. <u>Preventive care</u> and categories with a <u>copay</u> are covered before you meet your <u>deductible</u>.</p>  | <p>This <u>plan</u> covers some items and services even if you haven't yet met the annual <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 services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>   |
| <p>Are there other <u>deductibles</u> for specific services?</p>          | <p>No.</p>   | <p>You don't have to meet <u>deductibles</u> for specific services.</p>   |
| <p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>       | <p><u>Network</u>: \$1,500 Individual / \$3,000 Family<br/> <u>Non-Network</u>: \$3,000 Individual / \$6,000 Family<br/>                     Per calendar year. Prescription drugs have a separate limit of \$3,000 single /\$6,000 family In-network &amp; out-of-network combined.</p> | <p>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.</p>   |
| <p>What is not included in the <u>out-of-pocket limit</u>?</p>            | <p><u>Premiums</u>, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.</p>   | <p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>  |
| <p>Will you pay less if you use a <u>network provider</u>?</p>            | <p>Yes. See <a href="http://myuhc.com">myuhc.com</a> or call 1-866-633-2446 for a list of <u>network providers</u>.</p>  | <p>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 charge</u> 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.</p> |
| <p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>          | <p>No.</p>   | <p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>  |



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<br>(You will pay the least)                   | Out-of-Network Provider<br>(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 | \$20 <u>copay</u> per visit, <u>deductible</u> does not apply. | 30% <u>coinsurance</u>                             | Virtual visits (Telehealth) - \$20 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> , <u>deductible</u> does not apply. No virtual coverage out-of- <u>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                          | \$30 <u>copay</u> per visit, <u>deductible</u> does not apply. | 30% <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 out-of- <u>network</u> .  |
| If you have a test  | <u>Diagnostic test</u> (x-ray, blood work)       | No Charge  | 30% <u>coinsurance</u>                             | <u>Preauthorization</u> is required out-of- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .  |
|   | Imaging (CT/PET scans, MRIs)                     | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | <u>Preauthorization</u> is required out-of- <u>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](http://welcometouhc.com).

| Common Medical Event   | Services You May Need                          | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|--|--|--|--|---|
|  |  | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)             |   |
| <p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a></p> | Tier 1 – Your Lowest Cost Option               | Retail:<br>\$10 <u>copay, deductible</u> does not apply.<br>Mail-Order:<br>\$20 <u>copay, deductible</u> does not apply. | Not covered  | <p>Provider means pharmacy for purposes of this section.<br/>Retail: Up to a 30-day supply<br/>Mail-Order: Up to a 90-day supply<br/>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.<br/>Certain drugs may have a Pre-Notification requirement or may result in a higher cost. If you use a non-network pharmacy, you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.<br/>Tier 1 contraceptives covered at No Charge. See website listed for information on drugs charged by your plan.<br/>Not all drugs are covered.</p> |
|  | Tier 2 – Your Mid-Range Cost Option            | Retail:<br>\$20 <u>copay, deductible</u> does not apply.<br>Mail-Order:<br>\$50 <u>copay, deductible</u> does not apply. | Not covered  |   |
|  | Tier 3 – Your Mid-Range Cost Option            | Retail:<br>\$30 <u>copay, deductible</u> does not apply.<br>Mail-Order:<br>\$75 <u>copay, deductible</u> does not apply. | Not covered  |   |
|  | Tier 4 – Your Highest Cost Option              | Retail:<br>30% coinsurance, <u>deductible</u> does not apply. OR \$0 with Prudent Rx<br>Mail-Order:<br>Not Covered       | Not Covered  |   |
| <p><b>If you have outpatient surgery</b></p>   | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>   | <u>Preauthorization</u> is required out-of-network for certain services or benefit reduces to 50% of <u>allowed amount</u> .  |
|  | Physician/surgeon fees                         | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>   | None  |
| <p><b>If you need immediate medical attention</b></p>  | <u>Emergency room care</u>                     | \$75 <u>copay</u> per visit, <u>deductible</u> does not apply.   | \$75 <u>copay</u> per visit, <u>deductible</u> does not apply. | None  |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [welcometouhc.com](http://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) |  |
|   | <u>Emergency medical transportation</u>   | 10% <u>coinsurance</u>   | *10% <u>coinsurance</u>                         | * <u>Network deductible</u> applies  |
|   | <u>Urgent care</u>                        | \$30 <u>copay</u> per visit, <u>deductible</u> does not apply. | 30% <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)        | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                          | <u>Preauthorization</u> is required out-of- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .  |
|   | Physician/surgeon fees                    | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                          | None   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$20 <u>copay</u> per visit, <u>deductible</u> does not apply. | 30% <u>coinsurance</u>                          | <u>Network</u> Partial hospitalization/intensive outpatient treatment: 10% <u>coinsurance</u><br><u>Preauthorization</u> is required out-of- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .  |
|   | Inpatient services                        | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                          | <u>Preauthorization</u> is required out-of- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .  |
| If you are pregnant   | Office visits                             | No Charge  | 30% <u>coinsurance</u>                          | <u>Cost sharing</u> does not apply for <u>preventive services</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 | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                          |  |
|   | Childbirth/delivery facility services     | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                          | Inpatient <u>preauthorization</u> applies out-of- <u>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>                   | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                          | Limited to 60 visits per calendar year.<br><u>Preauthorization</u> is required out-of- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .   |
|   | <u>Rehabilitation services</u>            | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                          | Any combination of outpatient rehabilitation services is limited to 90 visits per calendar year.<br><u>Preauthorization</u> required out-of- <u>network</u> for certain services 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](http://welcometouhc.com).

| Common Medical Event                   | Services You May Need            | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|--|----------------------------------|--|--|--|
|  |                                  | Network Provider<br>(You will pay the least)                   | Out-of-Network Provider<br>(You will pay the most) |  |
|  | <u>Habilitative services</u>     | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | Services are provided under and limits are combined with <u>Rehabilitation Services</u> above. <u>Preauthorization</u> required out-of- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> . |
|  | <u>Skilled nursing care</u>      | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | Limited to 60 days per calendar year (combined with inpatient rehabilitation). <u>Preauthorization</u> is required out-of- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .                                   |
|  | <u>Durable medical equipment</u> | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | Covers 1 per type of DME (including repair/replacement) every 3 years. <u>Preauthorization</u> is required out-of- <u>network</u> for DME over \$1,000 or benefit reduces to 50% of <u>allowed amount</u> .                      |
|  | <u>Hospice services</u>          | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | <u>Preauthorization</u> is required out-of- <u>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              | \$20 <u>copay</u> per visit, <u>deductible</u> does not apply. | Not Covered  | Limited to 1 exam every year. No coverage out-of- <u>network</u> .   |
|  | 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](http://welcometouhc.com).

## 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"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li><li>• Dental care</li><li>• Glasses</li></ul>    | <ul style="list-style-type: none"><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when travelling outside - the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Private duty nursing</li><li>• Routine foot care – Except as covered for Diabetes</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 <u>plan</u> document.)                             |   |  |
| <ul style="list-style-type: none"><li>• Chiropractic (Manipulative care) – 90 visits per calendar year combined with Rehabilitation services</li></ul>          | <ul style="list-style-type: none"><li>• Routine eye care (adult) - 1 exam per year</li></ul>  | <ul style="list-style-type: none"><li>• Hearing aids - \$2,500 per calendar year</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, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://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](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 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](http://myuhc.com).

Additionally, a consumer assistance program may help you file your appeal. Contact [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-633-2446.

-----*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](http://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<br>(9 months of in-network pre-natal care and a hospital delivery)  |                 | Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)   |                | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)  |                |
|--|-----------------|--|----------------|--|----------------|
| ■ The <u>plan's</u> overall <u>deductible</u>  | \$275           | ■ The <u>plan's</u> overall <u>deductible</u>  | \$275          | ■ The <u>plan's</u> overall <u>deductible</u>  | \$275          |
| ■ <u>Specialist copay</u>  | \$30            | ■ <u>Specialist copay</u>  | \$30           | ■ <u>Specialist copay</u>  | \$30           |
| ■ Hospital (facility) <u>coinsurance</u>   | 10%             | ■ Hospital (facility) <u>coinsurance</u>   | 10%            | ■ Hospital (facility) <u>coinsurance</u>   | 10%            |
| ■ Other <u>coinsurance</u>   | 10%             | ■ Other <u>coinsurance</u>   | 10%            | ■ Other <u>coinsurance</u>   | 10%            |
| <p>This EXAMPLE event includes services like:<br/>                     Specialist office visits (<i>prenatal care</i>)<br/>                     Childbirth/Delivery Professional Services<br/>                     Childbirth/Delivery Facility Services<br/>                     Diagnostic tests (<i>ultrasounds and blood work</i>)<br/>                     Specialist visit (<i>anesthesia</i>)</p> |                 | <p>This EXAMPLE event includes services like:<br/>                     Primary care physician office visits (<i>including disease education</i>)<br/>                     Diagnostic tests (<i>blood work</i>)<br/>                     Prescription drugs<br/>                     Durable medical equipment (<i>glucose meter</i>)</p> |                | <p>This EXAMPLE event includes services like:<br/>                     Emergency room care (<i>including medical supplies</i>)<br/>                     Diagnostic test (<i>x-ray</i>)<br/>                     Durable medical equipment (<i>crutches</i>)<br/>                     Rehabilitation services (<i>physical therapy</i>)</p> |                |
| <b>Total Example Cost</b>  | <b>\$12,800</b> | <b>Total Example Cost</b>  | <b>\$7,400</b> | <b>Total Example Cost</b>  | <b>\$1,900</b> |
| In this example, Peg would pay:  |                 | In this example, Joe would pay:  |                | In this example, Mia would pay:  |                |
| <i>Cost Sharing</i>  |                 | <i>Cost Sharing</i>  |                | <i>Cost Sharing</i>  |                |
| <u>Deductibles</u>   | \$275           | <u>Deductibles</u>   | \$275          | <u>Deductibles</u>   | \$275          |
| <u>Copayments</u>  | \$40            | <u>Copayments</u>  | \$790          | <u>Copayments</u>  | \$170          |
| <u>Coinsurance</u>   | \$1,225         | <u>Coinsurance</u>   | \$186          | <u>Coinsurance</u>   | \$86           |
| <i>What isn't covered</i>  |                 | <i>What isn't covered</i>  |                | <i>What isn't covered</i>  |                |
| Limits or exclusions   | \$60            | Limits or exclusions   | \$55           | Limits or exclusions   | \$0            |
| <b>The total Peg would pay is</b>  | <b>\$1,600</b>  | <b>The total Joe would pay is</b>  | <b>\$1,306</b> | <b>The total Mia would pay is</b>  | <b>\$531</b>   |

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.

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