




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. 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: |
|---|--|---|
| <p>What is the overall <u>deductible</u>?</p> | <p><u>Network</u>: \$0 Individual / \$0 Family <u>Non-Network</u>: \$150 Individual / \$300 Family 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>.</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 <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 www.healthcare.gov/coverage/preventive-care-benefits/.</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>: \$650 Individual / \$1,300 Family <u>Non-Network</u>: \$1,000 Individual / \$2,000 Family Per calendar year. Prescription drugs have a separate limit of \$3,000 individual / \$6,000 family Network and Non-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>prenotification</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 myuhc.com 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> |

| | | |
|--|-----|--|
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | 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 |
|---|--|--|--|--|
| | | 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 | \$25 <u>copay</u> per visit, <u>deductible</u> does not apply. | 20% <u>coinsurance</u> | Virtual visits (Telehealth) - \$25 <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 | \$25 <u>copay</u> per visit, <u>deductible</u> does not apply. | 20% <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 | 20% <u>coinsurance</u> | <u>Prenotification</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) | No Charge | 20% <u>coinsurance</u> | <u>Prenotification</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.

| 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 prescription drug coverage is available at welcometouhc.com</p> | Tier 1 – Your Lowest Cost Option | Retail: \$15 <u>copay, deductible</u> does not apply. Mail-Order: \$30 <u>copay, deductible</u> does not apply. | Not covered | Provider means pharmacy for purposes of this section. Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. 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. Tier 1 contraceptives covered at No Charge. See website listed for information on drugs charged by your plan. Not all drugs are covered. |
| | Tier 2 – Your Mid-Range Cost Option | Retail: \$25 <u>copay, deductible</u> does not apply. Mail-Order: \$50 <u>copay, deductible</u> does not apply. | Not covered | |
| | Tier 3 – Your Mid-Range Cost Option | Retail: 35% <u>coinsurance</u> but not less than \$50 and not more than \$65, <u>deductible</u> does not apply. Mail-Order: 35% <u>coinsurance</u> but not less than \$100 and not more than \$130, <u>deductible</u> does not apply. | Not covered | |
| | Tier 4 – Your Highest Cost Option | Retail: 30% coinsurance, deductible does not apply OR \$0 with PrudentRx Mail-Order: Not Covered | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge | 20% <u>coinsurance</u> | None |

* 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) | |
| | Physician/surgeon fees | No Charge | 20% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$100 <u>copay</u> per visit, <u>deductible</u> does not apply. | \$100 <u>copay</u> per visit, <u>deductible</u> does not apply. | None |
| | <u>Emergency medical transportation</u> | No Charge | No Charge | None |
| | <u>Urgent care</u> | \$50 <u>copay</u> per visit, <u>deductible</u> does not apply. | 20% <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) | \$250 <u>copay</u> per admission, <u>deductible</u> does not apply. | 20% <u>coinsurance</u> | <u>Prenotification</u> is required out-of- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| | Physician/surgeon fees | No Charge | 20% <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. | 20% <u>coinsurance</u> | <u>Network</u> Partial hospitalization/intensive outpatient treatment: No Charge <u>Prenotification</u> is required out-of- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> . |
| | Inpatient services | \$250 <u>copay</u> per admission, <u>deductible</u> does not apply. | 20% <u>coinsurance</u> | <u>Prenotification</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 | 20% <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 | No Charge | 20% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | \$250 <u>copay</u> per admission, <u>deductible</u> does not apply. | 20% <u>coinsurance</u> | Inpatient <u>prenotification</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 | <u>Home health care</u> | No Charge | 20% <u>coinsurance</u> | Limited to 60 visits per calendar year. <u>Prenotification</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.

| 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) | |
| other special health needs | <u>Rehabilitation services</u> | \$25 <u>copay</u> per visit, <u>deductible</u> does not apply. | 20% <u>coinsurance</u> | Any combination of outpatient rehabilitation services is limited to 50 visits per calendar year. <u>Prenotification</u> required out-of- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> . |
| | <u>Habilitative services</u> | \$25 <u>copay</u> per visit, <u>deductible</u> does not apply. | 20% <u>coinsurance</u> | Services are provided under and limits are combined with <u>Rehabilitation Services</u> above. <u>Prenotification</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> | \$250 <u>copay</u> per admission, <u>deductible</u> does not apply. | 20% <u>coinsurance</u> | Skilled Nursing is limited to 300 days per calendar year. Inpatient rehabilitation limited to 120 days. <u>Prenotification</u> is required out-of- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> , <u>deductible</u> does not apply. | 50% <u>coinsurance</u> | Covers 1 per type of DME (including repair/replacement) every 3 years. <u>Prenotification</u> is required out-of- <u>network</u> for DME over \$1,000 or no coverage. |
| | <u>Hospice services</u> | No Charge | 20% <u>coinsurance</u> | <u>Prenotification</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 | \$25 <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.

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• Bariatric surgery• Cosmetic surgery• Dental care• Glasses | <ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when travelling outside - the U.S. | <ul style="list-style-type: none">• Private duty nursing• 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">• Chiropractic (Manipulative care) – 50 visits per calendar year | <ul style="list-style-type: none">• Routine eye care (adult) - 1 exam per year | <ul style="list-style-type: none">• Hearing aids - \$2,500 per calendar year, limited to once per three years |

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 1-866-633-2446.

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.

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- <u>network</u> pre-natal care and a hospital delivery) | Managing Joe's type 2 Diabetes (a year of routine in- <u>network</u> care of a well-controlled condition) | Mia's Simple Fracture (in- <u>network</u> emergency room visit and follow up care) |
|--|---|--|
|--|---|--|

| | | |
|--|--|--|
| <ul style="list-style-type: none"> ■ The <u>plan's</u> overall <u>deductible</u> \$0 ■ <u>Specialist copay</u> \$25 ■ Hospital (facility) <u>copay</u> \$250 ■ Other <u>coinsurance</u> 0% | <ul style="list-style-type: none"> ■ The <u>plan's</u> overall <u>deductible</u> \$0 ■ <u>Specialist copay</u> \$25 ■ Hospital (facility) <u>copay</u> \$250 ■ Other <u>coinsurance</u> 0% | <ul style="list-style-type: none"> ■ The <u>plan's</u> overall <u>deductible</u> \$0 ■ <u>Specialist copay</u> \$25 ■ Hospital (facility) <u>copay</u> \$250 ■ Other <u>coinsurance</u> 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*)

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 \$12,800 | Total Example Cost \$7,400 | Total Example Cost \$1,900 |
|------------------------------------|-----------------------------------|-----------------------------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| <u>Deductibles*</u> | \$0 |
| <u>Copayments</u> | \$300 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$360 |

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$700 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$30 |
| The total Joe would pay is | \$730 |

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$200 |

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.
