



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 1-866-351-6831 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 <u>deductible</u> ?	Network: \$0 Out-of-Network: \$500 Individual / \$1,500 Family Per calendar year.	Generally, you must pay all of the <u>deductible</u> amount before this plan begins to pay. If you have other family members on this plan, 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> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This plan 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 plan 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/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	Network: \$7,150 Individual / \$14,300 Family Out-of-Network: \$900 Individual / \$2,400 Family Per calendar year.	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 plan, 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.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>balance-billing</u> charges, health care this plan doesn't cover and penalties for failure to obtain <u>prenotification</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See myuhc.com or call 1-866-351-6831 for a list of <u>network providers</u> .	This plan uses a provider network. You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network</u> provider, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network</u> provider might use an out-of-network provider for some services (such as lab work). Check with your <u>provider</u> before you get services.
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 provider's 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>	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	20% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	20% <u>coinsurance</u>	None.
	<u>Imaging</u> (CT/PET scans, MRIs)	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	20% <u>coinsurance</u>	None.
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest Cost Option	Not Covered	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31-day supply. Mail-Order: Up to a 90-day supply. Covered by CVS Caremark. See www.Caremark.com for member information and drugs covered by your plan. CVS Caremark Customer Service: (844) 449-0372 / CVS Caremark Specialty Pharmacy: (800) 237-2767. PrudentRx – a \$0 Copay program requires enrollment. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have pre-authorization requirements or may result in higher costs. If you use a nonnetwork Pharmacy, you are responsible for any amount over the allowed amount.
	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 <u>copay</u> per visit, <u>deductible</u> does not apply	No Charge	None
	Physician/surgeon fees	No Charge	20% <u>coinsurance</u>	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	<u>Emergency room care</u>	\$45 <u>copay</u> per visit, deductible does not apply.	\$45 <u>copay</u> per visit, deductible does not apply.	None
	<u>Emergency medical transportation</u>	No Charge	No Charge	None
	<u>Urgent care</u>	\$25 <u>copay</u> per visit, deductible does not apply.	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	<u>Prenotification</u> is required or a \$250 penalty applies.
	Physician/surgeon fees	No Charge	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> per visit, deductible does not apply.	20% <u>coinsurance</u>	Network Partial hospitalization/intensive outpatient treatment: No Charge
	Inpatient services	No Charge	No Charge	None
If you are pregnant	Office visits	No Charge	20% <u>coinsurance</u>	Cost sharing 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	No Charge	No Charge	Inpatient <u>Prenotification</u> applies if stay exceeds 48 hours (C-Section: 96 hours) or a \$250 penalty applies.
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	No Charge	Limited to 365 visits per calendar year. <u>Prenotification</u> is required or a \$250 penalty applies.
	<u>Rehabilitation services</u>	\$25 <u>copay</u> per visit, deductible does not apply.	20% <u>coinsurance</u>	Limited to 25 visits per therapy, per calendar year.
	<u>Habilitative services</u>	\$25 <u>copay</u> per visit, deductible does not apply.	20% <u>coinsurance</u>	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	No Charge	No Charge	Limited to 365 days per calendar year (combined with inpatient rehabilitation). <u>Prenotification</u> is required or a \$250 penalty applies.
	<u>Durable medical equipment</u>	\$25 <u>copay</u> per visit, deductible does not apply.	20% <u>coinsurance</u>	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)	
				<u>Prenotification</u> is required for DME over \$1,000 or a \$250 penalty applies.
	<u>Hospice services</u>	No Charge	No Charge	<u>Prenotification</u> is required before admission for an Inpatient Stay in a hospice facility or a \$250 penalty applies.
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.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none">• Bariatric surgery• Cosmetic surgery• Dental care• Glasses• Hearing aids | <ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when travelling outside - the U.S.• Prescription drugs | <ul style="list-style-type: none">• 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.)

- | | | |
|---|--|--|
| <ul style="list-style-type: none">• Acupuncture | <ul style="list-style-type: none">• Chiropractic (Manipulative care) – 25 visits per calendar year | <ul style="list-style-type: none">• Private duty nursing |
|---|--|--|

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 1-866-351-6831.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-351-6831.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-351-6831.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-866-351-6831 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-351-6831.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-351-6831.

Carolinian (Kapasal Falawasch): ngere aukke ghut allis reel kapasal Falawasch au fafaingi tilifon ye 1-866-351-6831.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-866-351-6831.

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
n The plan's overall deductible	\$0	n The plan's overall deductible	\$0	n The plan's overall deductible	\$0
n Specialist copay	\$25	n Specialist copay	\$25	n Specialist copay	\$25
n Hospital (facility) coinsurance	0%	n Hospital (facility) coinsurance	0%	n Hospital (facility) coinsurance	0%
n Other coinsurance	0%	n Other coinsurance	0%	n Other coinsurance	0%
This EXAMPLE event includes services like: Specialist office visits (<i>pre-natal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$300	Copayments	\$300	Copayments	\$300
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$70	Limits or exclusions	\$4,300	Limits or exclusions	\$10
The total Peg would pay is	\$370	The total Joe would pay is	\$4,600	The total Mia would pay is	\$310

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