



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:
What is the overall deductible?	Network: <b>\$1,500</b> Individual / <b>\$3,000</b> Family Out-of-Network: <b>\$3,000</b> Individual / <b>\$6,000</b> Family Per policy year.	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> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and categories with a <u>copay</u> are covered before you meet your <u>deductible</u> .	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> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Network: <b>\$6,000</b> Individual / <b>\$12,000</b> Family Out-of-Network: <b>\$8,000</b> Individual / <b>\$16,000</b> Family Per policy 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 <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.
What is not included in the out-of-pocket limit?	<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.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.
Will you pay less if you use a network provider?	Yes. See <a href="http://myuhc.com">myuhc.com</a> or call 1-866-633-2446 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in the Designated <u>Network</u> . You pay more if you use a <u>provider</u> in the <u>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</u> charge 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.
Do you need a referral to see a specialist?	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.	50% <u>coinsurance</u>	Virtual visits - No Charge by a Designated Virtual <u>Network Provider</u> . 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. Office Visit cost share applies to any other Telehealth service based on <u>provider</u> type
	<u>Specialist</u> visit	\$50 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <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	50% <u>coinsurance</u>	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .

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)	
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://welcometouhc.com">welcometouhc.com</a>	Tier 1 – Your Lowest Cost Option	Retail: \$5 <u>copay, deductible</u> does not apply. Mail-Order: \$12.50 <u>copay, deductible</u> does not apply.	Retail: \$5 <u>copay, deductible</u> does not apply.	<u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. If you use an out-of- <u>network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable <u>copay</u> and/or <u>coinsurance</u> may be applied.
	Tier 2 – Your Mid-Range Cost Option	Retail: \$40 <u>copay, deductible</u> does not apply. Mail-Order: \$100 <u>copay, deductible</u> does not apply.	Retail: \$40 <u>copay, deductible</u> does not apply.	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$105 <u>copay, deductible</u> does not apply. Mail-Order: \$262.50 <u>copay, deductible</u> does not apply.	Retail: \$105 <u>copay, deductible</u> does not apply.	
	Specialty drugs	Retail: 250 <u>copay, deductible</u> does not apply. Mail-Order: \$625 <u>copay, deductible</u> does not apply.	Retail: \$250 <u>copay, deductible</u> does not apply.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Emergency room care</u>	\$300 <u>copay</u> per visit, <u>deductible</u> does not apply.	\$300 <u>copay</u> per visit, <u>deductible</u> does not apply.	None

If you need immediate medical attention	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	*20% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<u>Urgent care</u>	\$75 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <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 have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <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	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Network Partial hospitalization/intensive outpatient treatment: No Charge</u> <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	20% <u>coinsurance</u>	50% <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	50% <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	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <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	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 visits per policy year. <u>Preauthorization</u> is required out-of- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<u>Rehabilitation services</u>	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	Limits per policy year: Physical, Speech, Occupational, Pulmonary: 20 visits each; Cardiac: 36 visits <u>Preauthorization</u> required out-of- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .

needs	<u>Habilitative services</u>	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply	50% <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> .
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>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 days per policy 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>	20% <u>coinsurance</u>	50% <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>	20% <u>coinsurance</u>	50% <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	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	Limited to 1 exam every 2 years.
	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.)

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| <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>• 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> |
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### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none"><li>• Chiropractic (Manipulative care)-20 visits per policy year</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids - \$2,500 per policy year</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (adult) - 1 exam per 2 years</li></ul> |
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**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 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](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**

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.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-633-2446.

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

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-633-2446 uff.

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

Samoa (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2446.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2446.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-866-633-2446.

*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	\$1,500
■ Specialist copay	\$25
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$1,700
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,460</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,500
■ Specialist copay	\$25
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$20
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,250</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1,500
■ Specialist copay	\$25
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$40
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,040</b>

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