



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 1-866-844-4864 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: \$400 Individual / \$800 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> is 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 <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/ .
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: \$3,175 Individual / \$6,350 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, and health care this <u>plan</u> doesn't cover.	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 network provider?	Yes. See myuhc.com or call 1-866-844-4864 for a list of <u>network providers</u> .	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.
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)	Non-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	\$15 <u>copay</u> per visit	Not Covered	Virtual visits - \$15 <u>copay</u> per visit by a Designated Virtual Network Provider, <u>deductible</u> does not apply. Office visit Cost Share applies to any other Telehealth service based on <u>provider</u> type. If you receive services in addition to the office visit, additional <u>copays</u> or <u>coinsurance</u> may apply (e.g. surgery).
	<u>Specialist</u> visit	\$25 <u>copay</u> per visit	Not Covered	If you receive services in addition to the office visit, additional <u>copays</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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$100 <u>copay</u> per service	Not Covered	None
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest Cost Option	\$15 (31 Day Supply) \$37.50 (90 Day Supply)	Not Covered	Separate prescription drug annual out-of-pocket maximum applies: \$1,000 Single/\$3,000 Family. 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. Certain preventive medications (including certain contraceptives) 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.
	Tier 2 – Your Mid-Range Cost Option	\$30 (31 Day Supply) \$75 (90 Day Supply)	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	\$50 (31 Day Supply) \$125.00 (90 Day Supply)	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	

* 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)	Non-Network Provider (You will pay the most)	
				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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u> /service	Not Covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	Deductible applies, then \$150 <u>copay</u> per visit.	Deductible applies, then \$150 <u>copay</u> per visit.	None
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$25 <u>copay</u> per visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> per admission	Not Covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay</u> per visit	Not Covered	None
	Inpatient services	\$500 <u>copay</u> per admission	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	

* 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)	Non-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	0% <u>coinsurance</u>	Not Covered	<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 facility services	\$500 <u>copay</u> per admission	Not Covered	Inpatient <u>preauthorization</u> may apply.
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	Not Covered	None
	<u>Rehabilitation services</u>	\$25 <u>copay</u> per visit	Not Covered	Limits per policy year: Physical, Speech, Occupational: 60 visits each; Cardiac: 36 visits; Pulmonary: 20 visits.
	<u>Habilitative services</u>	\$25 <u>copay</u> per visit	Not Covered	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	\$500 <u>copay</u> per admission	Not Covered	Limited to 60 days per policy year (combined with inpatient rehabilitation).
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	Not Covered	None
	<u>Hospice services</u>	0% <u>coinsurance</u>	Not Covered	None
If your child needs dental or eye care	Children's eye exam	\$25 <u>copay</u> per visit	Not Covered	Limited to 1 exam every year.
	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 excluded services.)		
<ul style="list-style-type: none">• Bariatric surgery• Cosmetic surgery• Dental care• Glasses	<ul style="list-style-type: none">• 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">• Acupuncture – 12 visits per policy year• Chiropractic (Manipulative care) – 60 visits per policy year combined with Rehabilitation services	<ul style="list-style-type: none">• Hearing aids• Infertility treatment - limited to \$30,000 per lifetime.	<ul style="list-style-type: none">• Routine eye care (adult) - 1 exam per year

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.

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 1-866-844-4864.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-844-4864.

Traditional Chinese (中文): 如果需要中文的帮助, 請撥打這個號碼 1-866-844-4864.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-844-4864.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-866-844-4864 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-844-4864.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-844-4864.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-844-4864.

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)	
■ The plan's overall deductible	\$400	■ The plan's overall deductible	\$400	■ The plan's overall deductible	\$400
■ Specialist copay	\$25	■ Specialist copay	\$25	■ Specialist copay	\$25
■ Hospital (facility) copay	\$500	■ Hospital (facility) copay	\$500	■ Hospital (facility) copay	\$500
■ Other coinsurance	0%	■ Other coinsurance	0%	■ 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: <i>Cost Sharing</i>		In this example, Joe would pay: <i>Cost Sharing</i>		In this example, Mia would pay: <i>Cost Sharing</i>	
<u>Deductibles</u>	\$400	<u>Deductibles</u>	\$400	<u>Deductibles</u>	\$400
<u>Copayments</u>	\$500	<u>Copayments</u>	\$100	<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$100	Limits or exclusions	\$6,000	Limits or exclusions	\$0
The total Peg would pay is	\$1,000	The total Joe would pay is	\$6,500	The total Mia would pay is	\$800

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