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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>Network: $1,500 Individual / $3,000 Family Non-Network: $3,000 Individual / $6,000 Family Per policy year.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care is covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. 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></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Network: $3,425 Individual / $6,850 Family Non-Network: $7,500 Individual / $15,000 Family Per policy year.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover and penalties for failure to obtain preauthorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See myuhc.com or call 1-866-633-2446 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Virtual visits (Telehealth) - 10% coinsurance by a Designated Virtual Network Provider. No virtual coverage non-network</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization is required non-network for certain services or a $200 penalty applies.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization is required non-network or a $200 penalty applies.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 – Your Lowest Cost Option</td>
<td>Retail: 0% coinsurance Mail Order: 0% coinsurance</td>
<td>Retail: 0% coinsurance</td>
<td>Provider 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 specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to</td>
</tr>
<tr>
<td></td>
<td>Tier 2 – Your Mid-Range Cost Option</td>
<td>Retail: 20% coinsurance Mail Order: 20% coinsurance</td>
<td>Retail: 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 – Your Mid-Range Cost Option</td>
<td>Retail: 20% coinsurance Mail Order: 20% coinsurance</td>
<td>Retail: 20% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Non-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Tier 4 – Your Highest Cost Option</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>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 copay and/or coinsurance may be applied. Prescription drug costs are subject to the annual deductible. Network deductible will be applied to the non-network provider and applies to the Network out-of-pocket limit</td>
</tr>
</tbody>
</table>

| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not covered | None |
|                               | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | None |

| If you need immediate medical attention | Emergency room care | 20% coinsurance | *20% coinsurance | *Network deductible applies |
|                                         | Emergency medical transportation | 20% coinsurance | *20% coinsurance | *Network deductible applies |
|                                         | Urgent care | 20% coinsurance | 50% coinsurance | None |

| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | Preauthorization is required non-network or a $200 penalty applies. |
|                            | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | None |

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.
<table>
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<tr>
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<th>Services You May Need</th>
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<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance. Preauthorization is required non-network for certain services or a $200 penalty applies. Preauthorization is required non-network or a $200 penalty applies.</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Inpatient preauthorization applies non-network if stay exceeds 48 hours (C-Section: 96 hours) or a $200 penalty applies.</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to 60 visits per policy year. Preauthorization is required non-network or a $200 penalty applies.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Limits per policy year: Physical/Occupational/ Speech: combined limit 60 visits; Cardiac: 36 visits; Pulmonary: 36 visits. Preauthorization required non-network for certain services or a $200 penalty applies.</td>
<td></td>
</tr>
<tr>
<td>Habilitative services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Services are provided under and limits are combined with Rehabilitation Services above. Preauthorization required non-network for certain services or a $200 penalty applies.</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to 60 days per policy year (combined with inpatient rehabilitation). Preauthorization is required non-network or a $200 penalty applies.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Covers 1 per type of DME (including repair/replacement) every</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at welcomeuhc.com.
### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>3 years. Preauthorization is required non-network for DME over $1,000 or a $200 penalty applies. Preauthorization is required non-network before admission for an Inpatient Stay in a hospice facility or a $200 penalty applies.</td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to 1 exam every 2 years.</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to initial purchase of eyeglasses or contact lenses after cataract surgery. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both.</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>No coverage for Children’s Dental check-up.</td>
</tr>
</tbody>
</table>

#### 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.)**

- Acupuncture
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Prescription drugs
- 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 plan document.)**

- Bariatric surgery
- Chiropractic (Manipulative care)
- Glasses (adult) - after cataract surgery only
- Hearing aids - $2,500 per policy year
- Routine eye care (adult) - 1 exam per 2 years

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*For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).*
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
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:
Navajo (Dine): Dinek’e hogh shika at’ohwol ninisingo, kwijijgo holne’ 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 coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost:** $12,800

**In this example, Peg would pay:**
- Cost Sharing
  - Deductibles: $1,500
  - Copayments: $0
  - Coinsurance: $1,900
- What isn’t covered
  - Limits or exclusions: $100
- The total Peg would pay is: $3,500

### 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 coinsurance: 20%
- 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)

**Total Example Cost:** $7,400

**In this example, Joe would pay:**
- Cost Sharing
  - Deductibles: $1,000
  - Copayments: $0
  - Coinsurance: $0
- What isn’t covered
  - Limits or exclusions: $6,000
- The total Joe would pay is: $7,000

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $1,500
- Specialist coinsurance: 20%
- 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)

**Total Example Cost:** $1,900

**In this example, Mia would pay:**
- Cost Sharing
  - Deductibles: $1,500
  - Copayments: $0
  - Coinsurance: $90
- What isn’t covered
  - Limits or exclusions: $0
- The total Mia would pay is: $1,590

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

**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](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf)

**Complaint forms are available at [http://www.hhs.gov/ocr/office/file/index.html](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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**ATENCIÓN:** Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

**請注意：**如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

**XIN LUÚ Y:** Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đại thoại bảo hiểm (Summary of Benefits and Coverage, SBC) này.
세션을 제공하는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benefisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чьё родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po polsku (Polish), udostępnimy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all’interno di questo Sommario dei Benefici e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されているフリー ダイヤルにてお電話ください。
توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زیبایی به طور رایگان در انتخاب شما می‌باشد. لطفاً با شماره تلفن رایگان دکتر شما در این خلاصه مزایا و پیشنهاد مانند بهترین (Summary of Benefits and Coverage, SBC) تماس بگیرید.