



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:   |
|--|---|---|
| <u>What is the overall deductible?</u>                             | \$0   | See the Common Medical Events Chart below for your costs for services this <u>plan</u> covers.  |
| <u>Are there services covered before you meet your deductible?</u> | No.   | See the Common Medical Events Chart below for your costs for services this <u>plan</u> covers.  |
| <u>Are there other deductibles for specific services?</u>          | No.   | You don't have to meet <u>deductibles</u> for specific services.  |
| <u>What is the out-of-pocket limit for this plan?</u>              | <u>Network: \$2,000</u> Individual / <u>\$4,000</u> 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 <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.   |
| <u>What is not included in the out-of-pocket limit?</u>            | <u>Premiums</u> , <u>balance-billing</u> charges, 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> .  |
| <u>Will you pay less if you use a network provider?</u>            | Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-633-2446 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</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. |
| <u>Do you need a referral to see a 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 | \$15 <b>copay</b> per visit, <b>deductible</b> does not apply | Not Covered                                     | If you receive services in addition to office visit, additional <b>copays</b> , <b>deductibles</b> or <b>coinsurance</b> may apply e.g. surgery.                        |
|  | <u>Specialist visit</u>                          | \$15 <b>copay</b> per visit, <b>deductible</b> does not apply | Not Covered                                     | If you receive services in addition to office visit, additional <b>copays</b> , <b>deductibles</b> or <b>coinsurance</b> 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)       | No Charge   | Not Covered                                     | None  |
|  | Imaging (CT/PET scans, MRIs)                     | No Charge   | Not Covered                                     | 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) |   |
| <b>If you need drugs to treat your illness or condition</b><br>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.<br>Mail-Order: \$10 <u>copay, deductible</u> does not apply.  | Not Covered                                     | <u>Provider</u> means pharmacy for purposes of this section.<br>Retail: Up to a 31 day supply.<br>Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy.<br>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 <u>out-of-network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> .<br>Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge.<br>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            | Retail: \$25 <u>copay, deductible</u> does not apply.<br>Mail-Order: \$50 <u>copay, deductible</u> does not apply. | Not Covered                                     |   |
|  | Tier 3 - Your Mid-Range Cost Option            | Retail: \$40 <u>copay, deductible</u> does not apply.<br>Mail-Order: \$80 <u>copay, deductible</u> does not apply. | Not Covered                                     |   |
|  | Tier 4 - Your Highest Cost Option              | Retail: \$45 <u>copay, deductible</u> does not apply.<br>Mail-Order: \$90 <u>copay, deductible</u> does not apply. | Not Applicable                                  |   |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | \$200 <u>copay/service, deductible</u> does not apply  | Not Covered                                     | None  |
|  | Physician/surgeon fees                         | No Charge  | Not Covered                                     | 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>                | \$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>                        | \$15 <u>copay</u> per visit, <u>deductible</u> does not apply      | Not Covered  | None   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | \$100 <u>copay</u> per admission, <u>deductible</u> does not apply | Not Covered  | None   |
|   | Physician/surgeon fees                    | No Charge  | Not Covered  | None   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$15 <u>copay</u> per visit, <u>deductible</u> does not apply      | Not Covered  | <u>Network All Other: No Charge.</u><br>See your policy or <u>plan</u> document for additional information about Employee Assistance Program (EAP) benefits.   |
|   | Inpatient services                        | \$100 <u>copay</u> per admission, <u>deductible</u> does not apply | Not Covered  | See your policy or <u>plan</u> document for additional information about EAP benefits.   |
| If you are pregnant   | Office Visits                             | No Charge  | Not Covered  | <u>Cost sharing</u> does not apply for <u>preventive services</u> .  |
|   | Childbirth/delivery professional services | No Charge  | Not Covered  | 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     | \$100 <u>copay</u> per admission, <u>deductible</u> does not apply | Not Covered  | None   |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | No Charge  | Not Covered  | Limited to 100 visits per calendar year.   |

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://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) |   |
|   | <u>Rehabilitation services</u>   | \$15 <u>copay</u> per visit,<br><u>deductible</u> does not apply      | Not Covered                                     | Outpatient <u>rehabilitation services</u> are unlimited per calendar year.<br>No limits apply for treatment of Autism Spectrum Disorder Services. |
|   | <u>Habilitative services</u>     | \$15 <u>copay</u> per visit,<br><u>deductible</u> does not apply      | Not Covered                                     | Services are provided under <u>Rehabilitation Services</u> above.<br>No limits apply for treatment of Autism Spectrum Disorder Services.          |
|   | <u>Skilled nursing care</u>      | \$100 <u>copay</u> per admission,<br><u>deductible</u> does not apply | Not Covered                                     | Skilled Nursing is limited to 100 days per calendar year.   |
|   | <u>Durable medical equipment</u> | No Charge   | Not Covered                                     | None  |
|   | <u>Hospice services</u>          | No Charge   | Not Covered                                     | None  |
| <b>If your child needs dental or eye care</b> | Children's eye exam              | \$15 <u>copay</u> per visit,<br><u>deductible</u> does not apply      | Not Covered                                     | Limited to 1 exam every 24 months.  |
|   | 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.)

|                    |  |  |
|--------------------|--|--|
| • Cosmetic Surgery | • Long Term Care                                     | • Private duty nursing                               |
| • Dental Care      | • Non-emergency care when traveling outside - the US | • Routine foot care - Except as covered for Diabetes |
| • Glasses          |  |  |

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

|  |  |   |
|--|--|---|
| • Acupuncture - 20 visits per calendar year                      | • Hearing aids - \$2,500 per calendar year | • Routine eye care (Adult) - 1 exam per 24 months |
| • Bariatric surgery - 1 procedure per lifetime                   | • Infertility Treatment                    | • Weight loss programs- Real Appeal               |
| • Chiropractic (manipulative) care - 24 visits per calendar 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: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or [www.dmhc.ca.gov](http://www.dmhc.ca.gov), or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>. 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 or the Employee Benefits Security Administration at 1-866-444-3272 or [dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

Additionally, a consumer assistance program may help you file your appeal. Contact Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or [www.dmhc.ca.gov](http://www.dmhc.ca.gov).

#### **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, kwijjigo holne' 1-866-633-2446.

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

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

Samoan (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, å'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)

|  |       |
|--|-------|
| ■ <u>The plan's overall deductible</u> | \$0   |
| ■ <u>Specialist copay</u>              | \$15  |
| ■ <u>Hospital (facility) copay</u>     | \$100 |
| ■ <u>Other 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)

**Total Example Cost**      \$12,700

**In this example, Peg would pay:**

| <u>Cost Sharing</u> |       |
|---------------------|-------|
| <u>Deductibles</u>  | \$0   |
| <u>Copayments</u>   | \$100 |
| <u>Coinsurance</u>  | \$0   |

**What isn't covered**

|                                   |              |
|-----------------------------------|--------------|
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$160</b> |

### Managing Joe's type 2 Diabetes

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

|  |       |
|--|-------|
| ■ <u>The plan's overall deductible</u> | \$0   |
| ■ <u>Specialist copay</u>              | \$15  |
| ■ <u>Hospital (facility) copay</u>     | \$100 |
| ■ <u>Other coinsurance</u>             | 0%    |

**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**      \$5,600

**In this example, Joe would pay:**

| <u>Cost Sharing</u> |       |
|---------------------|-------|
| <u>Deductibles</u>  | \$0   |
| <u>Copayments</u>   | \$300 |
| <u>Coinsurance</u>  | \$0   |

**What isn't covered**

|                                   |              |
|-----------------------------------|--------------|
| Limits or exclusions              | \$0          |
| <b>The total Joe would pay is</b> | <b>\$300</b> |

### Mia's Simple Fracture

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

|  |       |
|--|-------|
| ■ <u>The plan's overall deductible</u> | \$0   |
| ■ <u>Specialist copay</u>              | \$15  |
| ■ <u>Hospital (facility) copay</u>     | \$100 |
| ■ <u>Other coinsurance</u>             | 0%    |

**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**      \$2,800

**In this example, Mia would pay:**

| <u>Cost Sharing</u> |       |
|---------------------|-------|
| <u>Deductibles</u>  | \$0   |
| <u>Copayments</u>   | \$400 |
| <u>Coinsurance</u>  | \$0   |

**What isn't covered**

|                                   |              |
|-----------------------------------|--------------|
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$400</b> |

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