**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.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: $250 Individual / $750 Family<br>Out-of-Network: $250 Individual / $750 Family<br>Per calendar year. | 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and categories with a copay may be covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the 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 preventive services at www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Network: $2,250 Individual / $4,500 Family<br>Out-of-Network: $6,500 Individual / $13,000 Family<br>Per calendar year. | 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.myuhc.com or call 1-866-633-2446 for a list of network providers. | 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. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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 | $20 copay per visit, deductible does not apply | 30% coinsurance | None |
| | Specialist visit | $20 copay per visit, deductible does not apply | 30% coinsurance | None |
| | Preventive care/ screening/ immunization | No Charge | Not Covered | 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.<br>No coverage out-of-network. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab Testing:<br>Free Standing/Office:<br>No Charge<br>Hospital:<br>10% coinsurance, deductible does not apply<br>X-Ray/Diagnostics:<br>10% coinsurance, deductible does not apply | Lab Testing:<br>Not Covered<br>X-Ray/Diagnostics:<br>30% coinsurance | No coverage out-of-network for lab testing.<br>Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |

| 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 drugs to treat your illness or condition**<br><br>More information about prescription drug coverage is available at welcometouhc.com | Tier 1 - Your Lowest Cost Option | Retail: $5 copay, deductible does not apply<br>Mail-Order: $10 copay, deductible does not apply | Retail: $5 copay, deductible does not apply | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 31-day supply.<br>Mail-Order or Preferred 90-Day Retail Network pharmacy: Up to a 90-day supply.<br>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 an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.<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 plan. 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 copay, deductible does not apply<br>Mail-Order: $50 copay, deductible does not apply | Retail: $25 copay, deductible does not apply | |
| | Tier 3 - Your Mid-Range Cost Option | Retail: $40 copay, deductible does not apply<br>Mail-Order: $80 copay, deductible does not apply | Retail: $40 copay, deductible does not apply | |
| | Tier 4 – Your Highest Cost Option | Retail: $45 copay, deductible does not apply<br>Mail-Order: $90 copay, deductible does not apply | Retail: $45 copay, deductible does not apply | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Ambulatory Surgical Center/Office: $150 copay/service, deductible does not apply<br>Hospital: 10% coinsurance | 30% coinsurance | Out-of-network allowed amounts for Facility Fees are limited to $760 per date of service.<br>Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $150 copay per visit then 10% coinsurance, deductible does not apply | $150 copay per visit then 10% coinsurance, deductible does not apply | None |
| | Emergency medical transportation | 10% coinsurance | *10% coinsurance | *Network deductible applies. |
| | Urgent care | $20 copay per visit, deductible does not apply | 30% coinsurance | 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) | 10% coinsurance | 30% coinsurance | Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 copay per visit, deductible does not apply | 30% coinsurance | Network Partial hospitalization/intensive outpatient treatment: 10% coinsurance<br>Network Intensive Behavior Therapy (ABA), TMS, ECT, MAT and Psych Testing: 10% coinsurance, deductible does not apply<br>Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.<br>See your policy or plan document for additional information about Employee Assistance Program (EAP) benefits. |
| | Inpatient services | 10% coinsurance | 30% coinsurance | Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.<br>See your policy or plan document for additional information about EAP benefits. |
| **If you are pregnant** | Office visits | No Charge | 30% coinsurance | Cost sharing does not apply for preventive services.<br>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). Benefits include Doula Services. |
| | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount. |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 30% coinsurance | Limited to 100 visits per calendar year.<br>Out-of-network allowed amounts for Home health care are limited to $150 per visit.<br>Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |

| 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) | |
| | Rehabilitation services | $20 copay per visit, deductible does not apply | 30% coinsurance | Limits per calendar year: Physical, Occupational, Speech, Pulmonary, Cardiac: Unlimited<br>No limits apply for treatment of Autism Spectrum Disorder Services.<br>No coverage out-of-network for physical and occupational therapy.<br>Visits limits do not apply for the treatment of mental illness or substance-related & addictive disorders. |
| | Habilitative services | $20 copay per visit, deductible does not apply | 30% coinsurance | Services are provided under and limits are combined with Rehabilitation Services above.<br>No limits apply for treatment of Autism Spectrum Disorder Services.<br>No coverage out-of-network for physical and occupational therapy. |
| | Skilled nursing care | 10% coinsurance | 30% coinsurance | Skilled nursing is limited to 100 days per calendar year.<br>Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| | Durable medical equipment | 10% coinsurance | Not Covered | No coverage out-of-network. |
| | Hospice services | 10% coinsurance | 30% coinsurance | Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount. |
| **If your child needs dental or eye care** | Children's eye exam | $20 copay per visit, deductible does not apply | Not Covered | Limited to 1 exam every 24 months.<br>No coverage out-of-network. |
| | 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 | • Glasses | • Non-emergency care when traveling outside the US |
| • Dental care (Adult) | • Long Term Care | • Private duty nursing |

| 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 - $2500 per calendar year | • Routine foot care (covered for certain conditions) |
| • Bariatric surgery | • Infertility treatment | • Weight loss programs - Real Appeal |
| • Chiropractic (manipulative) care - 24 visits per calendar year | • Routine eye care (Adult) - 1 exam per 24 months | |

**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, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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 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.

**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 (Diné): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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.
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.*

*For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

## 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 | $250 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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:** | |
| *Cost Sharing* | |
| Deductibles | $250 |
| Copayments | $10 |
| Coinsurance | $1000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1320** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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:** | |
| *Cost Sharing* | |
| Deductibles | $200 |
| Copayments | $300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$500** |

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

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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:** | |
| *Cost Sharing* | |
| Deductibles | $250 |
| Copayments | $400 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$850** |

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