



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 1-833-312-1227 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:
<b>What is the overall deductible?</b>	<u>Network</u> : \$4,400 Individual / \$8,750 Family <u>Out-of-Network</u> : \$4,400 Individual / \$8,750 Family Per calendar 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> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your deductible?</b>	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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<u>Network</u> : \$4,400 Individual / \$8,750 Family <u>Out-of-Network</u> : \$6,000 Individual / \$12,000 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.
<b>What is not included in the out-of-pocket limit?</b>	<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.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://myuhc.com">myuhc.com</a> or call 1-833-312-1227 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.
<b>Do you need a referral to see a specialist?</b>	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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Specialist visit</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge	30% <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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or a \$500 penalty applies.
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or a \$500 penalty applies.
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at cap-rx.com	Generic Drugs	0% <u>coinsurance</u> after deductible is met	Not Covered	Prescription Drug Coverage offered through Capital Rx. Deductible does not apply for certain preventive medications. Covers 30-day supply (retail) and 90-day supply retail and mail order. <b>First fill</b> for new utilizers is limited to a 30-day supply.
	Brand Drugs	0% <u>coinsurance</u> after deductible is met	Not Covered	
	Specialty Drugs	Copays align with retail copay structure	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or a \$500 penalty applies.
	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>	*0% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	*0% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<u>Urgent care</u>	0% <u>coinsurance</u>	30% <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)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or a \$500 penalty applies.
	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or a \$500 penalty applies.
	Inpatient services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or a \$500 penalty applies.
If you are pregnant	Office visits	No Charge	30% <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	0% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 120 visits per calendar year. <u>Preauthorization</u> is required <u>out-of-network</u> or a \$500 penalty applies.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Limits per calendar year: Physical, Speech, Occupational: 60 visits each; Cardiac: Unlimited; Pulmonary: Unlimited. <u>Preauthorization</u> is required <u>out-of-network</u> for certain services or a \$500 penalty applies.

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

	<u>Habilitative services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above. <u>Preauthorization</u> is required <u>out-of-network</u> for certain services or a \$500 penalty applies.
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 90 days per calendar year (combined with inpatient rehabilitation). <u>Preauthorization</u> is required <u>out-of-network</u> or a \$500 penalty applies.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for DME over \$1,000 or a \$500 penalty 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)	
	<u>Hospice services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility or a \$500 penalty applies.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care</li> <li>Glasses</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</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>Routine eye care</li> <li>Routine foot care – Except as covered for Diabetes</li> <li>Weight loss programs</li> </ul>
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"> <li>Bariatric surgery</li> <li>Chiropractic (Manipulative care) – 40 visits per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment - Limited to \$20,000 per lifetime/additional \$5,000 per lifetime for single embryo transfer.</li> </ul>	<ul style="list-style-type: none"> <li>Private duty nursing- 70 visits per calendar year Outpatient</li> </ul>

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

**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) or the Employee Benefits Security Administration at 1-866-444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

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 1-833-312-1227.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-312-1227.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-312-1227.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-833-312-1227 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-312-1227.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-312-1227.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-312-1227.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, á'gang 1-833-312-1227.

*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)	
■ <b>The plan's overall deductible</b>	<b>\$4,400</b>	■ <b>The plan's overall deductible</b>	<b>\$4,400</b>	■ <b>The plan's overall deductible</b>	<b>\$4,400</b>
■ <b>Specialist coinsurance</b>	<b>0%</b>	■ <b>Specialist coinsurance</b>	<b>0%</b>	■ <b>Specialist coinsurance</b>	<b>0%</b>
■ <b>Hospital (facility) coinsurance</b>	<b>0%</b>	■ <b>Hospital (facility) coinsurance</b>	<b>0%</b>	■ <b>Hospital (facility) coinsurance</b>	<b>0%</b>
■ <b>Other coinsurance</b>	<b>0%</b>	■ <b>Other coinsurance</b>	<b>0%</b>	■ <b>Other coinsurance</b>	<b>0%</b>
<p><b>This EXAMPLE event includes services like:</b>  <u>Specialist</u> office visits (<i>pre-natal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services  <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>)  <u>Specialist</u> visit (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>  <u>Primary care physician</u> office visits (<i>including disease education</i>)  <u>Diagnostic tests</u> (<i>blood work</i>)  <u>Prescription drugs</u>  <u>Durable medical equipment</u> (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>  <u>Emergency room care</u> (<i>including medical supplies</i>)  <u>Diagnostic test</u> (<i>x-ray</i>)  <u>Durable medical equipment</u> (<i>crutches</i>)  <u>Rehabilitation services</u> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<u>Deductibles</u>	\$4,400	<u>Deductibles</u>	\$4,400	<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0	<u>Copayments</u>	\$0	<u>Copayments</u>	\$0
<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	\$60	Limits or exclusions	\$0	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,460</b>	<b>The total Joe would pay is</b>	<b>\$4,400</b>	<b>The total Mia would pay is</b>	<b>\$2,800</b>

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