



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 <u>deductible</u>?</b>	<u>Network</u> : <b>\$2,500</b> Individual / <b>\$5,000</b> Family <u>Out-of-Network</u> : <b>\$4,000</b> Individual / <b>\$8,000</b> 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 <u>deductible</u>?</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 <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<u>Network</u> : <b>\$4,400</b> Individual / <b>\$8,750</b> Family <u>Out-of-Network</u> : <b>\$6,000</b> Individual / <b>\$12,000</b> 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 <u>out-of-pocket limit</u>?</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 limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</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 <u>referral</u> to see a <u>specialist</u>?</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	Tier 1: 10% <u>coinsurance</u> Tier 2: 20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	Tier 1: 10% <u>coinsurance</u> Tier 2: 20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	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)	20% <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)	20% <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>  <b>More information about <u>prescription drug coverage</u> is available at <a href="http://cap-rx.com">cap-rx.com</a></b>	Generic Brand Drugs	Retail (30-day supply): \$10 copay after deductible. Retail (90-day supply): \$30 copay after deductible. Mail-Order (90-day supply): \$20 copay after deductible.	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. First fill for new utilizers is limited to a 30-day supply.
	Preferred Brand Drugs	Retail (30-day supply): \$50 copay after deductible. Retail (90-day supply): \$150 copay after deductible. Mail-Order (90-day supply): \$100 copay after deductible.	Not Covered	
	Non-Preferred Drugs	Retail (30-day supply): \$100 copay after deductible. Retail (90-day supply): \$300 copay after deductible.	Not Covered	

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

		Mail-Order (90-day supply): \$200 copay after deductible.		
	Specialty Drugs	Copays align with retail copay structure	Not Applicable	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <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	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% <u>coinsurance</u>	*20% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	*20% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<u>Urgent care</u>	20% <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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <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	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <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	20% <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 are pregnant</b>	Office visits	No Charge	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</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	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Inpatient <u>preauthorization</u> applies <u>out-of-network</u> if stay exceeds 48 hours (C-Section: 96 hours) or a \$500 penalty applies.
<b>If you need help recovering or have</b>	<u>Home health care</u>	20% <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.

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

<b>other special health needs</b>	<u>Rehabilitation services</u>	20% <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.
	<u>Habilitative services</u>	20% <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>	20% <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>	20% <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>	20% <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.
<b>If your child needs dental or eye care</b>	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> <li>Prescription drugs</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.)		

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

<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 \$10,000 per lifetime.</li></ul>	<ul style="list-style-type: none"><li>• Private duty nursing- 70 visits per calendar year Outpatient</li></ul>
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\* 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): 如果需要中文的幫助, 請撥打這個號碼 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)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist</u> coinsurance	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,700
What isn't covered	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$4,270</b>

### Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist</u> coinsurance	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,050
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$5,350</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist</u> coinsurance	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$60
What isn't covered	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$2,570</b>

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