



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.welcometouhc.com or by calling 1-800-782-3740.

| Important Questions | Answers | Why this Matters: |
|--|---|---|
| What is the overall deductible? | Network: \$750 Indiv / \$1,500 Family Non-Network: \$1,500 Indiv / \$3,000 Family Per calendar year. Does not apply to prescription drugs, services listed below as "No Charge" and copays except as noted below. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an out-of-pocket limit on my expenses? | Yes, Network: \$5,500 Indiv / \$11,000 Family Non-Network: \$11,000 Indiv / \$22,000 Family | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits. |
| Does this plan use a network of providers? | Yes. For a list of network providers , see www.welcometouhc.com or call 1-800-782-3740. | If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers . |
| Do I need a referral to see a specialist? | No. | You can see the specialist you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services . |

Questions: Call 1-800-782-3740 or visit us at www.welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|--|--|---|--|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$20 copay per visit | 50% co-ins, after ded | If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. |
| | Specialist visit | \$40 copay per visit | 50% co-ins, after ded | If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. |
| | Other practitioner office visit | \$20 copay per visit | 50% co-ins, after ded | Includes Acupuncture and Manipulative (Chiropractic) Services. Manipulative (Chiropractic) Services are limited to 24 visits per year. Pre-Authorization required for non-network or benefit reduces by \$1,000 per visit. |
| | Preventive care/screening-immunization | No Charge | Not Covered | No coverage non-Network. Includes preventive health services specified in the health care reform law. |
| If you have a test | Diagnostic test (x-ray, blood work) | Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded | 50% co-ins, after ded | Pre-Authorization required for non-network for sleep studies or benefit reduces by \$1,000 per visit. \$250 Hospital-Based per occurrence Copayment applies prior to the Annual Deductible. |
| | Imaging (CT/PET scans, MRIs) | Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded | 50% co-ins, after ded | \$250 Hospital-Based per occurrence Copayment applies prior to the Annual Deductible. Pre-Authorization required for non-network or benefit reduces by \$1,000 per visit. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|--|---|---|---|--|
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.welcometouhc.com . | Tier 1 - Your Lowest-Cost Option | Retail: \$15 copay Mail-Order: \$37.50 copay | Retail: \$15 copay | Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may not be covered until prior authorization is obtained. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered unless medically necessary. 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 Co-ins may be applied. Tier 1 contraceptives are covered at No Charge. |
| | Tier 2 - Your Midrange-Cost Option | Retail: \$35 copay Mail-Order: \$87.50 copay | Retail: \$35 copay | |
| | Tier 3 - Your Highest-Cost Option | Retail: \$60 copay Mail-Order: \$150 copay | Retail: \$60 copay | |
| | Tier 4 (if applicable) - Additional High-Cost Options | Retail: 25% co-ins with a \$250 copay max. Mail-Order: 25% co-ins with a \$625 copay max. | Retail: 25% co-ins with a \$250 copay max. | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Ambulatory Surg Center / Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded | 50% co-ins, after ded | Pre-Authorization required for certain services for non-network or benefit reduces \$1,000 per surgery. \$250 Hospital-Based per occurrence Copayment applies prior to the Annual Deductible. |
| | Physician/surgeon fees | 20% co-ins, after ded | 50% co-ins, after ded | |
| If you need immediate medical attention | Emergency room services | \$100 copay per visit | \$100 copay per visit | Copayment waived if admitted directly to hospital. |
| | Emergency medical transportation | 20% co-ins, after ded | 20% co-ins, after ded | Network Deductible applies. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|--|--|---|--|
| | Urgent care | \$50 copay per visit | 50% co-ins, after ded | If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% co-ins, after ded | 50% co-ins, after ded | Pre-Authorization required for non-network or benefit reduces by \$1,000 per admission. \$250 Inpatient Stay per occurrence Copayment applies prior to the Annual Deductible. |
| | Physician/surgeon fee | 20% co-ins, after ded | 50% co-ins, after ded | None |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | Outpatient Office Visits: \$20 copay per visit . All other outpatient Treatment: 20% co-ins, after ded | 50% co-ins, after ded | Pre-Authorization required for certain services for non-network or benefit reduces by \$1,000 per visit. |
| | Mental/Behavioral health inpatient services | 20% co-ins, after ded | 50% co-ins, after ded | Pre-Authorization required for non-network or benefit reduces by \$1,000 per admission. |
| | Substance use disorder outpatient services | Outpatient Office Visits: \$20 copay per visit . All other outpatient Treatment: 20% co-ins, after ded | 50% co-ins, after ded | Pre-Authorization required for certain services for non-network or benefit reduces by \$1,000 per visit. |
| | Substance use disorder inpatient services | 20% co-ins, after ded | 50% co-ins, after ded | Pre-Authorization required for non-network or benefit reduces by \$1,000 per admission. |
| If you are pregnant | Prenatal and postnatal care | No Charge | 50% co-ins, after ded | Additional copays, deductibles, or co-ins may apply depending on services rendered. Applies to routine prenatal care and office visits. One post-natal office visit is covered. |
| | Delivery and all inpatient services | 20% co-ins, after ded | 50% co-ins, after ded | Inpatient Authorization may apply. \$250 Inpatient Stay per occurrence Copayment applies prior to the Annual Deductible. |
| If you need help recovering or have other special health needs | Home health care | 20% co-ins, after ded | 50% co-ins, after ded | Limited to 100 visits per policy year. Pre-Authorization required for non-network or benefit reduces by \$1,000 per visit. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---------------------------|---|---|--|
| | Rehabilitation services | \$20 copay per outpatient visit | 50% co-ins, after ded | Pre-Authorization required for certain services for non-network or benefit reduces by \$1,000 per visit. |
| | Habilitative services | \$20 copay per outpatient visit | 50% co-ins, after ded | Pre-Authorization required for certain services for non-network or benefit reduces by \$1,000 per visit. |
| | Skilled nursing care | 20% co-ins, after ded | 50% co-ins, after ded | Limited to 100 days per benefit period (combined with Inpatient Rehabilitation) . Pre-Authorization required for non-network or benefit reduces by \$1,000 per admission. |
| | Durable medical equipment | 20% co-ins, after ded | 50% co-ins, after ded | Pre-Authorization required for non-network DME over \$1,000 or benefit reduces by \$1,000 per item. |
| | Hospice service | 20% co-ins, after ded | 50% co-ins, after ded | Inpatient Pre-Authorization required for non-network or benefit reduces by \$1,000 per admission |
| If your child needs dental or eye care | Eye exam | No Charge | 50% co-ins | One exam per year. |
| | Glasses | 20% co-ins | 50% co-ins | One pair per year. |
| | Dental check-up | No Charge | 20% co-ins | Cleanings covered 2 times per 12 months. Additional limitations may apply. |

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care - 24 visits per year
- Hearing aids - 1 every 3 years; \$2500 per year
- Infertility treatment - \$2000 lifetime
- Routine eye care (Adult) - 1 exam every year

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact us at 1-800-782-3740; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

You may also contact the California Department of Insurance, Consumer Communications Bureau Health Unit, 300 South Spring Street, South Tower, Los Angeles, CA 90013 or at 1-800-927-HELP (4357), 1-800-482-4833 TDD or at www.insurance.ca.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Insurance at the contact information provided above.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-782-3740.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-782-3740.

Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiiijigo holne' 1-800-782-3740.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$5,220**
- **Patient pays \$2,320**

Sample care costs:

| | |
|----------------------------|----------------|
| Hospital charges (mother) | \$2,700 |
| Routine obstetric care | \$2,100 |
| Hospital charges (baby) | \$900 |
| Anesthesia | \$900 |
| Laboratory tests | \$500 |
| Prescriptions | \$200 |
| Radiology | \$200 |
| Vaccines, other preventive | \$40 |
| Total | \$7,540 |

Patient pays:

| | |
|----------------------|----------------|
| Deductibles | \$1,000 |
| Copays | \$20 |
| Coinsurance | \$1,100 |
| Limits or exclusions | \$200 |
| Total | \$2,320 |

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$3,660**
- **Patient pays \$1,740**

Sample care costs:

| | |
|--------------------------------|----------------|
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures | \$700 |
| Education | \$300 |
| Laboratory tests | \$100 |
| Vaccines, other preventive | \$100 |
| Total | \$5,400 |

Patient pays:

| | |
|----------------------|----------------|
| Deductibles | \$300 |
| Copays | \$1,400 |
| Coinsurance | \$0 |
| Limits or exclusions | \$40 |
| Total | \$1,740 |

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

x No . Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

x No . Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes . When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes . An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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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>

Complaint forms are available at <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.