



 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, visit [www.welcometouhc.com/uhcwest](http://www.welcometouhc.com/uhcwest) or by calling 1-800-624-8822. 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 1-800-624-8822 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and primary care services are 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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>participating providers</u> \$7,500 individual / \$15,000 family.	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.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, optional addenda, and 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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.welcometouhc.com/uhcwest">www.welcometouhc.com/uhcwest</a> or call 1-800-624-8822 for a list of <u>participating 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 a <u>non-participating 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>participating provider</u> might use a <u>non-participating provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes, written or oral approval is required, based upon medical policies.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$35 <u>copay</u> / office visit and No charge / Virtual visits by a designated virtual <u>participating provider</u>	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> or <u>coinsurance</u> may apply.
	<a href="#">Specialist</a> visit	\$70 <u>copay</u> / visit	Not covered	Member is required to obtain a <u>referral</u> to <u>specialist</u> or other licensed health care practitioner, except for OB/GYN <u>Physician services</u> , reproductive health care services within the <u>Participating Medical Group</u> and Emergency / Urgently needed services. If you receive services in addition to office visit, additional <u>copayments</u> or <u>coinsurance</u> may apply.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab \$40 <u>copay</u> / test Radiology (Standard) \$40 <u>copay</u> / test	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$200 <u>copay</u> / test	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.welcometouhc.com/uhcwest">prescription drug coverage</a> is available at <a href="http://www.welcometouhc.com/uhcwest">www.welcometouhc.com/uhcwest</a> .	Tier 1	\$15 <u>copay</u> / prescription retail \$30 <u>copay</u> / prescription mail order \$15 <u>copay</u> / <u>specialty drugs</u>	Not covered	<u>Participating Provider</u> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. When applicable: Mail-Order <u>Specialty drugs</u> - Up to a 31 day supply. All limits are unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <u>Copayment</u> Maximum of \$250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a <u>plan</u> design not defined as a High <u>Deductible Health Plan</u> regardless of any <u>Deductible</u> . 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 <u>plan</u> .
	Tier 2	\$50 <u>copay</u> / prescription retail \$100 <u>copay</u> / prescription mail order \$150 <u>copay</u> / <u>specialty drugs</u>	Not covered	
	Tier 3	\$85 <u>copay</u> / prescription retail \$170 <u>copay</u> / prescription mail order \$250 <u>copay</u> / <u>specialty drugs</u>	Not covered	
	Tier 4	25% <u>coinsurance</u> / prescription retail up to a \$250 <u>copay</u> max per prescription 25% <u>coinsurance</u> / prescription mail order up to a \$500 <u>copay</u> max per prescription 25% <u>coinsurance</u> / <u>specialty drugs</u> up to a \$250 <u>copay</u> max per prescription	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$400 <u>copay</u> / admit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$400 <u>copay</u> / visit	\$400 <u>copay</u> / visit	<u>Copayment</u> waived if admitted.
	<a href="#">Emergency medical transportation</a>	\$100 <u>copay</u> / trip	\$100 <u>copay</u> / trip	None
	<a href="#">Urgent care</a>	\$35 <u>copay</u> / visit	\$100 <u>copay</u> / visit	If you receive services in addition to <u>urgent care</u> , additional <u>copayments</u> or <u>coinsurance</u> may apply.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$600 <u>copay</u> / day	Not covered	<u>Copayment</u> applies to a maximum of 4 days per stay.
	Physician/surgeon fees	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copay</u> / office visit and \$150 <u>copay</u> for all other outpatient services	Not covered	None
	Inpatient services	\$600 <u>copay</u> / day	Not covered	<u>Copayment</u> applies to a maximum of 4 days per stay.
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Routine pre-natal care and first postnatal visit is covered at No charge.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$600 <u>copay</u> / day	Not covered	<u>Copayment</u> applies to a maximum of 4 days per stay. Depending on the type of services, additional <u>copayments</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$35 <u>copay</u> / visit	Not covered	Limited to 100 visits per year. Limit does not apply to home health visits for rehabilitation and habilitation purposes.
	<a href="#">Rehabilitation services</a>	\$35 <u>copay</u> / visit	Not covered	None
	<a href="#">Habilitative services</a>	\$35 <u>copay</u> / visit	Not covered	
	<a href="#">Skilled nursing care</a>	\$300 <u>copay</u> / day	Not covered	<u>Copayment</u> applies to a maximum of 4 days per stay. Up to 100 days per benefit period.
	<a href="#">Durable medical equipment</a>	\$70 <u>copay</u> / item	Not covered	None
	<a href="#">Hospice services</a>	No charge	Not covered	If inpatient admission, subject to inpatient <u>copayments</u> or <u>coinsurance</u> .
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 exam per year.
	Children's glasses	10% <u>coinsurance</u>	Not covered	One pair every 12 months.
	Children's dental check-up	No charge	Not covered	Cleanings covered 2 times per 12 months. Additional limitations may apply.

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

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Routine eye care (Adult)

**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 are: Department of Managed Health Care California Help Center, 980 9<sup>th</sup> 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: your human resource department, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <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 9<sup>th</sup> 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 1-800-624-8822.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-8822.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-624-8822.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-624-8822.

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 participating provider pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$70
- Hospital (facility) [copayment](#) \$600/day
- 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*)

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

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,300
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,360</b>

**Managing Joe's Type 2 Diabetes**

(a year of routine participating provider care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$70
- Hospital (facility) [copayment](#) \$600/day
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visit (*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	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,500
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,500</b>

**Mia's Simple Fracture**

(participating provider emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$70
- Hospital (facility) [copayment](#) \$600/day
- 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*)

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

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$900</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-624-8822.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

**Subject to Regulatory Approval**