



 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<br>(You will pay the least)   | Non-Participating Provider<br>(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<br>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<br>Radiology (Standard) \$40 <u>copay</u> / test  | Not covered   | None   |
|  | Imaging (CT/PET scans, MRIs)                           | \$300 <u>copay</u> / test  | Not covered   |  |

| Common Medical Event  | Services You May Need                            | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|---|--|---|---|--|
|   |  | Participating Provider<br>(You will pay the least)  | Non-Participating Provider<br>(You will pay the most) |  |
| <b>If you need drugs to treat your illness or condition</b><br>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<br>\$30 <u>copay</u> / prescription mail order<br>\$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.<br><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<br>\$100 <u>copay</u> / prescription mail order<br>\$150 <u>copay</u> / <u>specialty drugs</u>  | Not covered   |  |
|   | Tier 3   | \$100 <u>copay</u> / prescription retail<br>\$200 <u>copay</u> / prescription mail order<br>\$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<br>25% <u>coinsurance</u> / prescription mail order up to a \$500 <u>copay</u> max per prescription<br>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)   | \$500 <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>              | \$500 <u>copay</u> / visit  | \$500 <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)               | \$700 <u>copay</u> / day  | Not covered   | <u>Copayment</u> applies to a maximum of 5 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<br>(You will pay the least)  | Non-Participating Provider<br>(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     | \$700 <u>copay</u> / day  | Not covered   | <u>Copayment</u> applies to a maximum of 5 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 5 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      | • Long-term care                                     | • Routine foot care    |
| • Dental care (Adult)   | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Infertility treatment | • Private-duty nursing                               |                        |

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

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

**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](#) \$700/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> |
|---------------------------|-----------------|

In this example, Peg 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              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,560</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](#) \$700/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> |
|---------------------------|----------------|

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](#) \$700/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> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$1,000        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,000</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.