
 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 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/ or call 1-800-624-8822 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$2,500/individual or \$5,000/family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care , primary care, specialist visits, testing and tier 1 drugs are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. Prescription drugs – \$300 individual / \$600 family – applies to Tiers 2 through 4 drugs. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	For participating providers \$8,600 individual / \$17,200 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Copayments for certain services, premiums , balance-billing charges, optional addenda, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.welcometouhc.com/uhcwest or call 1-800-624-8822 for a list of participating providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use a non-participating provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your participating provider might use a non-participating provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes, written or oral approval is required, based upon medical policies.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$55 copay / office visit and \$55 copay / Virtual visits by a designated virtual participating provider ; deductible does not apply	Not covered	If you receive services in addition to office visit, additional copayments , deductibles or coinsurance may apply.
	Specialist visit	\$90 copay / visit; deductible does not apply	Not covered	Member is required to obtain a referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services , reproductive health care services within the Participating Medical Group and Emergency / Urgently needed services. If you receive services in addition to office visit, additional copayments , deductibles or coinsurance may apply.
	Preventive care/screening/immunization	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab \$55 copay / test Radiology (Standard) \$90 copay / test; deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	35% coinsurance	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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.welcometouhc.com/uhcwest .	Tier 1	\$20 <u>copay</u> / prescription retail \$40 <u>copay</u> / prescription mail order; <u>deductible</u> does not apply	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	\$75 <u>copay</u> / prescription retail \$150 <u>copay</u> / prescription mail order	Not covered	
	Tier 3	\$105 <u>copay</u> / prescription retail \$210 <u>copay</u> / prescription mail order	Not covered	
	Tier 4	30% <u>coinsurance</u> / prescription retail up to a \$250 <u>copay</u> max per prescription 30% <u>coinsurance</u> / prescription mail order up to a \$500 <u>copay</u> max per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	35% <u>coinsurance</u> ; <u>deductible</u> does not apply	Not covered	
If you need immediate medical attention	Emergency room care	Facility Fee: 35% <u>coinsurance</u> Physician Fee: No charge; <u>deductible</u> does not apply	Facility Fee: 35% <u>coinsurance</u> Physician Fee: No charge; <u>deductible</u> does not apply	<u>Copayment</u> waived if admitted.
	Emergency medical transportation	35% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Urgent care	\$55 <u>copay</u> / visit; <u>deductible</u> does not apply	\$55 <u>copay</u> / visit; <u>deductible</u> does not apply	If you receive services in addition to <u>urgent care</u> , additional <u>copayments</u> , <u>deductibles</u> or <u>coinsurance</u> may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	35% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	35% <u>coinsurance</u>	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$55 <u>copay</u> / office visit and No charge for all other outpatient services; <u>deductible</u> does not apply	Not covered	None
	Inpatient services	35% <u>coinsurance</u>	Not covered	
If you are pregnant	Office visits	No charge; <u>deductible</u> does not apply	Not covered	Cost sharing does not apply to certain <u>preventive services</u> . Routine pre-natal care and first postnatal visit is covered at No charge. Depending on the type of services, additional <u>copayments</u> , <u>deductibles</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge; <u>deductible</u> does not apply	Not covered	
	Childbirth/delivery facility services	35% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	Home health care	35% <u>coinsurance</u> ; <u>deductible</u> does not apply	Not covered	Limited to 100 visits per year. Limit does not apply to home health visits for rehabilitation and habilitation purposes.
	Rehabilitation services	\$55 <u>copay</u> / visit; <u>deductible</u> does not apply	Not covered	None
	Habilitative services	\$55 <u>copay</u> / visit; <u>deductible</u> does not apply	Not covered	
	Skilled nursing care	35% <u>coinsurance</u>	Not covered	Up to 100 days per benefit period.
	Durable medical equipment	35% <u>coinsurance</u> ; <u>deductible</u> does not apply	Not covered	None
	Hospice services	No charge; <u>deductible</u> does not apply	Not covered	If inpatient admission, subject to inpatient <u>copayments</u> , <u>deductibles</u> or <u>coinsurance</u> .
If your child needs dental or eye care	Children's eye exam	No charge; <u>deductible</u> does not apply	Not covered	1 exam per year.
	Children's glasses	No charge; <u>deductible</u> does not apply	Not covered	One pair per year.
	Children's dental check-up	No charge; <u>deductible</u> does not apply	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](#).)

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

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

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

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 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or 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 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 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or 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](#) \$2,500
- [Specialist copayment](#) \$90
- Hospital (facility) [coinsurance](#) 35%
- Other [coinsurance](#) 35%

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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$200
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,860

Managing Joe's Type 2 Diabetes

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

- The [plan's overall deductible](#) \$2,500
- [Specialist copayment](#) \$90
- Hospital (facility) [coinsurance](#) 35%
- Other [coinsurance](#) 35%

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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$1,900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,200

Mia's Simple Fracture

([participating provider emergency room visit](#) and follow up care)

- The [plan's overall deductible](#) \$2,500
- [Specialist copayment](#) \$90
- Hospital (facility) [coinsurance](#) 35%
- Other [coinsurance](#) 35%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000

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