
 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.cciio.cms.gov or call 1-800-624-8822 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$2,000/individual or \$4,000/family.	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> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. <u>Prescription drugs</u> – \$200 individual / \$400 family – applies to Tiers 2 through 4 drugs. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>participating providers</u> \$6,750 individual / \$13,500 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 www.welcometouhc.com/uhcwest 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 charge</u> 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> .

 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 <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	\$45 <u>copay</u> / office visit and \$25 <u>copay</u> / Virtual visits by a designated virtual <u>participating provider</u> ; <u>deductible</u> does not apply	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductibles</u> or <u>coinsurance</u> may apply.
	<u>Specialist</u> visit	\$65 <u>copay</u> / visit; <u>deductible</u> does not apply	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> 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> , <u>deductibles</u> or <u>coinsurance</u> may apply.
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab \$25 <u>copay</u> / test Radiology (Standard) \$25 <u>copay</u> / test; <u>deductible</u> does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$200 <u>copay</u> / test; <u>deductible</u> does not apply	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 – Your Lowest-Cost Option	\$20 <u>copay</u> / prescription retail \$40 <u>copay</u> / prescription mail order; <u>deductible</u> does not apply	Not covered	<u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 30 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. <u>Coinsurance/Copayment</u> Maximum of \$200 for up to a 30 day supply of an orally administered anticancer medication regardless of a <u>Prescription Drug Deductible</u> and/or <u>Medical 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 – Your Midrange-Cost Option	\$50 <u>copay</u> / prescription retail \$100 <u>copay</u> / prescription mail order	Not covered	
	Tier 3 – Your Highest-Cost Option	\$100 <u>copay</u> / prescription retail \$200 <u>copay</u> / prescription mail order	Not covered	
	Tier 4 – Additional High-Cost Options	25% <u>coinsurance</u> / prescription retail up to a \$250 copay max per prescription 25% <u>coinsurance</u> / prescription mail order up to a \$500 copay max per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	40% <u>coinsurance</u> ; <u>deductible</u> does not apply	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$400 <u>copay</u> / visit; <u>deductible</u> does not apply	\$400 <u>copay</u> / visit; <u>deductible</u> does not apply	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	\$100 <u>copay</u> / trip; <u>deductible</u> does not apply	\$100 <u>copay</u> / trip; <u>deductible</u> does not apply	None
	<u>Urgent care</u>	\$45 <u>copay</u> / visit; <u>deductible</u> does not apply	\$100 copay / 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)	40% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	40% <u>coinsurance</u> ; <u>deductible</u> does not apply	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	\$65 <u>copay</u> / office visit and No charge for all other outpatient services; <u>deductible</u> does not apply	Not covered	None
	Inpatient services	40% <u>coinsurance</u>	Not covered	
If you are pregnant	Office visits	No charge; <u>deductible</u> does not apply	Not covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . 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	40% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$45 <u>copay</u> / visit; <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.
	<u>Rehabilitation services</u>	\$45 <u>copay</u> / visit; <u>deductible</u> does not apply	Not covered	None
	<u>Habilitative services</u>	\$45 <u>copay</u> / visit; <u>deductible</u> does not apply	Not covered	
	<u>Skilled nursing care</u>	40% <u>coinsurance</u>	Not covered	Up to 100 days per benefit period.
	<u>Durable medical equipment</u>	\$50 <u>copay</u> / item; <u>deductible</u> does not apply	Not covered	Durable medical equipment for the treatment of pediatric asthma: No charge.
	<u>Hospice services</u>	No charge; <u>deductible</u> does not apply	Not covered	If inpatient admission, subject to inpatient <u>copayments</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 every 12 months.
	Children's glasses	40% <u>coinsurance</u> ; <u>deductible</u> does not apply	Not covered	One pair every 12 months.
	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.)**

- | | | |
|-------------------------|--|------------------------|
| • 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 is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <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 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 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, the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact California Department of Managed Health Care Help Center at 1-888-466-2219 or <http://www.healthhelp.ca.gov>.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.-----



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 \$2,000
- Specialist copayment \$65
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost \$12,800

In this example, Peg would pay:

Cost Sharing	
*Deductibles	\$2,000
Copayments	\$100
Coinsurance	\$2,700
What isn't covered	
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 \$2,000
- Specialist copayment \$65
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

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)

Total Example Cost \$7,400

In this example, Joe would pay:

Cost Sharing	
*Deductibles	\$200
Copayments	\$1,900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$30
The total Joe would pay is	\$2,130

Mia's Simple Fracture

(participating provider emergency room visit and follow up care)

- The plan's overall deductible \$2,000
- Specialist copayment \$65
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

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 \$1,900

In this example, Mia would pay:

Cost Sharing	
*Deductibles	\$0
Copayments	\$700
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$750

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. *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

The company does 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.

o **Online:** UHC_Civil_Rights@uhc.com

o **Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box30608, Salt Lake City, UT 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 member toll-free phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

o **Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

o **Phone:** Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

o **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 member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniłmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) ស្វែងរកជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់ អ្នក។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yániiti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shqódí ninaaltsoos nít'izí bee nééhozinígíí bine'déé' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodílnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.