



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, call 1-888-567-4659 or visit welcometouhc.com. 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 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network: \$750 Individual / \$2,250 Family</u> Per calendar year.	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> is 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
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>?	<u>Network: \$3,000 Individual / \$5,500 Family</u> Per calendar year.	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>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain for services.	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 myuhc.com or call 1-888-567-4659 for a list of <u>network 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 an <u>out-of-network 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>network provider</u> might use an <u>out-of-network 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>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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
		Network Provider (You will pay the least)	Out-of-Network 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	20% <u>coinsurance</u>	Not Covered	Virtual visits - No Charge by a Designated Virtual <u>Network</u> Provider. Office visit cost share applies to any other Telehealth service based on provider type.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	Not Covered	None
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not Covered	Preferred Lab – 100% no deductible.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not Covered	None
If you need drugs to treat your illness or condition	\$0 Copay Generic Drugs	Some generic medications have a \$0 copay	Not Covered	Prescription Drug Coverage is provided through Liviniti. For more information on pharmacy benefits and programs, please contact Liviniti. Customer Service: 800-710-9341 Website: https://www.liviniti.com/
	Over-the-Counter Drugs	Retail 30 Day: \$2 Retail 90 Day: \$6 Mail Order: \$6	Not Covered	
	Generic	Retail 30 Day: \$10 copay Retail 90 Day: \$25 copay Mail Order: \$25 copay	Not Covered	
	Preferred Brand	Retail 30 Day: \$25 copay Retail 90 Day: \$75 copay Mail Order: \$75 copay	Not Covered	
	Non-Preferred Brand	Retail 30 Day: \$50 copay Retail 90 Day: \$160 copay Mail Order: \$160 copay	Not Covered	
	Specialty	30 Day: \$200 copay	Not Applicable	

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	Freestanding ER: \$1,000 <u>copay</u> per visit, then 20% <u>coinsurance</u> . Hospital-Based ER: \$250 <u>copay</u> per visit, then 20% <u>coinsurance</u>	Freestanding ER: \$1,000 <u>copay</u> per visit, then 20% <u>coinsurance</u> . Hospital-Based ER: \$250 <u>copay</u> per visit, then *20% <u>coinsurance</u> .	* <u>Network deductible</u> applies Separate Emergency Room Out-of-Pocket Copay limit of \$2,000 per year
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	*20% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<u>Urgent care</u>	\$50 <u>copay</u> per visit, then 20% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	None

* For more information about limitations and exceptions, see the [plan](#) or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	Not Covered	Limit to 60 visits per calendar year. <u>Network</u> Partial hospitalization/intensive outpatient treatment: 20% <u>coinsurance</u> . See your policy or <u>plan</u> document for additional information about EAP benefits.
	Inpatient services	20% <u>coinsurance</u>	Not Covered	See your policy or <u>plan</u> document for additional information about EAP benefits.
If you are pregnant	Office visits	No Charge	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not Covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not Covered	Limited to 60 visits per calendar year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u> .	Not Covered	Limits per calendar year: Physical, Speech, Occupational, Pulmonary: 20 visits each; Cardiac: 36 visits
	<u>Habilitative services</u>	20% <u>coinsurance</u> .	Not Covered	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not Covered	Limited to 180 days per calendar year (combined with inpatient rehabilitation).
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years.
	<u>Hospice services</u>	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to 1 exam every year.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care• Glasses• Hearing aids | <ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when travelling outside - the U.S.• Prescription drugs | <ul style="list-style-type: none">• Private duty nursing• Routine foot care – Except as covered for Diabetes• Weight loss programs |
|---|---|--|

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

- | | |
|--|--|
| <ul style="list-style-type: none">• Chiropractic (Manipulative care) – 20 visits per calendar year | <ul style="list-style-type: none">• Routine eye care (adult) - 1 exam per year |
|--|--|

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: 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. 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: the Member Service number listed on the back of your ID card or myuhc.com. Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

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 1-888-567-4659.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-567-4659.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-567-4659.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-888-567-4659uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-567-4659.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-567-4659.

Carolinian (Kapasal Falawasch): ngere aukke ghut allilis reel kapasal Falawasch au fafaingi tilifon ye 1-888-567-4659.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-888-567-4659

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

