**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 (866) 351-6831 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 (866) 487-2365 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: **$0** Individual / **$0** Family<br>Non-Network: **$600** Individual / **$1,200** Family<br>Per calendar year. | 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 and categories with a copay are covered before you meet your deductible.<br>. | This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply.<br>For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Network: **$3,000** Individual / **$6,000** Family<br>Non-Network **$2,000** Individual / **$4,000** Family<br>Per calendar year. | 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?** | Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain Prenotification for services. | 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. This plan uses network providers. If you use a non-network provider your cost may be more. For a list of providers, see myuhc.com for UHC Options PPO network, www.empireplanproviders.com/provider.htm for Empire Plan Network, or call (866) 351-6831, or United Behavioral Health (UBH) at myuhc.com or (866) 374-6060. | 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 an out-of-network 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 network provider might use an out-of-network 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?** | No. | You can see the specialist you choose without a referral. |

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) | Non-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 | $25 copay per visit | 20% coinsurance | Virtual visits - $15 copay per visit by a Designated Virtual Network Provider, deductible does not apply. No virtual coverage out-of-network<br>If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply. |
| | Specialist visit | $40 copay per visit, deductible does not apply. | 20% coinsurance | If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. |
| | Preventive care/screening/ immunization | No Charge | 20% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $25 copay per test, deductible does not apply. | 20% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | $25 copay per service, deductible does not apply. | 20% coinsurance | 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) | Non-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** | Tier 1 – Your Lowest Cost Option | Retail: $10 copay<br>Mail-Order: $20 copay | Retail: $10 copay<br>Mail-Order: Not Covered | Provider means pharmacy for purposes of this section. Retail: Up to a 31-day supply. Mail-Order: Up to a 90-day supply. Covered by CVS Caremark. See www.Caremark.com for member information and drugs covered by your plan. CVS Caremark Customer Service: (844) 449-0372 / CVS Caremark Specialty Pharmacy: (800) 237-2767. PrudentRx – a $0 Copay program requires enrollment. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have pre-authorization requirements or may result in higher costs. If you use a non-network Pharmacy, you are responsible for any amount over the allowed amount. Not all drugs are covered. |
| | Tier 2 – Your Mid-Range Cost Option | Retail: $30 copay<br>Mail-Order: $60 copay | Retail: $30 copay<br>Mail-Order: Not Covered | |
| | Tier 3 – Your Mid-Range Cost Option | Retail: $45 copay<br>Mail-Order: $90 copay | Retail: $45 copay<br>Mail-Order: Not Covered | |
| | Tier 4 – Your Highest Cost Option | Not Applicable | Not Applicable | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge | 20% coinsurance | None |
| | Physician/surgeon fees | No Charge | 20% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $150 copay per visit, deductible does not apply. | $150 copay per visit, deductible does not apply. | None |
| | Emergency medical transportation | No Charge | No Charge | None |
| | Urgent care | $40 copay per visit, deductible does not apply. | 20% coinsurance | If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | No Charge | Prenotification is required or a $250 penalty applies. |
| | Physician/surgeon fees | No Charge | 20% coinsurance | 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) | Non-Network Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay per visit, deductible does not apply. | 20% coinsurance | Network Partial hospitalization/intensive outpatient treatment: No Charge |
| | Inpatient services | No Charge | No Charge | Prenotification is required or a $250 penalty applies. |
| **If you are pregnant** | Office visits | No Charge | 20% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | No Charge | 20% coinsurance | |
| | Childbirth/delivery facility services | No Charge | No Charge | Prenotification applies if stay exceeds 48 hours (C-Section: 96 hours) or a $250 penalty applies. |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | No Charge | Prenotification is required or a $250 penalty applies. |
| | Rehabilitation services | $40 copay per visit, deductible does not apply. | 20% coinsurance | Limited to 25 visits per therapy, per calendar year. . |
| | Habilitative services | $40 copay per visit, deductible does not apply. | 20% coinsurance | Services are provided under and limits are combined with Rehabilitation Services above. |
| | Skilled nursing care | No Charge | No Charge | None. |
| | Durable medical equipment | $25 copay per device, deductible does not apply | 20% coinsurance | A single purchase of any one type of equipment is covered each 3 years including needed repairs. |

* 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) | Non-Network Provider (You will pay the most) | |
| | Hospice services | No Charge | No Charge | Prenotification is required before admission for an Inpatient Stay in a hospice facility or a $250 penalty applies. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | No coverage for Children's eye exams. |
| | 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. |

## 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.)**

- Children's glasses
- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine eye care
- 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.)**

- Acupuncture
- Bariatric surgery
- Chiropractic (Manipulative care) – 25 visits per calendar year
- Hearing aids
- Infertility treatment – limited to 3 cycles per lifetime

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

**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 (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (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 (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: 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**
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 (866) 351-6831.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (866) 351-6831.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (866) 351-6831.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (866) 351-6831.

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

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

## 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 in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copay | $40 |
| Hospital (facility) copay | $0 |
| Other coinsurance | 0% |

**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 | $0 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $100 |
| **The total Peg would pay is** | **$300** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copay | $40 |
| Hospital (facility) copay | $0 |
| Other coinsurance | 0% |

**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 | $0 |
| Copayments | $1,000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,060** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copay | $40 |
| Hospital (facility) copay | $0 |
| Other coinsurance | 0% |

**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 | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$400** |

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

We do 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.
**Online:** UHC_Civil_Rights@uhc.com
**Mail**: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 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 toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
**Online:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
**Phone:** Toll-free (800) 368-1019, (800) 537-7697 (TDD)
**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 number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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