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 1-844-585-1273 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 deductible?	Network: **$5,000** Individual / **$10,000** Family 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 is covered before you meet your deductible.	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. 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: **$7,500** Individual / **$15,000** Family 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, 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 myuhc.com or call **1-844-585-1273** for a list of network providers.	You pay the least if you use a provider in the Designated Network. You pay more if you use a provider in the 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)	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	Designated Network: $40 Copay Network: $60 Copay	Not Covered	Virtual visits (Telehealth) - 0% coinsurance by a Designated Virtual Network Provider.
	Specialist visit	Designated Network: $60 Copay Network: $80 Copay	Not Covered	None
	Preventive care/screening/ immunization	No Charge	Not Covered	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)	Free Standing/Office: 10% coinsurance Hospital: 20% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: 10% coinsurance Hospital: 20% coinsurance	Not Covered	None

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 drugs to treat your illness or condition	Tier 1 – Your Lowest Cost Option	Retail: $20 copay. Mail-Order: $50 copay.	Not Covered	Prescription drug coverage is provided through Elixir Insurance. For a list of participating pharmacies, go to www.elixirinsurance.com or call 1- 833-803-4402. Retail coverage applies up to a 31-day supply. Plan covers up to a 90-day supply via mail order and up to a 90-day supply of maintenance drugs via participating retail pharmacy. Certain drugs may be subject to quantity limits. Brand additional charge may also apply.
	Tier 2 – Your Mid-Range Cost Option	Retail: $35 copay. Mail-Order: $87.50 copay	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: $50 copay. Mail-Order: $125 copay.	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center/Office: 10% coinsurance Hospital: 20% coinsurance	Not Covered	None
	Physician/surgeon fees	Designated Network: 10% coinsurance Network: 20% coinsurance	Not Covered	None

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 immediate medical attention	Emergency room care	20% coinsurance	*20% coinsurance	*Network deductible applies
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network deductible applies
	Urgent care	$75 Copay	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	Designated Network: 10% coinsurance Network: 20% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 Copay	Not Covered	Network Partial hospitalization/intensive outpatient treatment: 10% coinsurance. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	20% coinsurance	Not Covered	See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office visits	$40 Copay	Not Covered	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	Designated Network: 10% coinsurance Network: 20% coinsurance	Not Covered	
	Childbirth/delivery facility services	20% coinsurance	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 help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	None
	Rehabilitation services	$40 Copay	Not Covered	Limited to 60 visits per therapy, per calendar year.
	Habilitative services	$40 Copay	Not Covered	Services are provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	20% coinsurance	Not Covered	None
	Durable medical equipment	20% coinsurance	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice services	20% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	$40 Copay	Not Covered	Limited to 1 exam every 1 year.
	Children's glasses	Not Covered	Not Covered	Covered under vision benefits
	Children's dental check-up	Not Covered	Not Covered	Covered under dental benefits

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 • Dental care • Glasses	• Infertility treatment • Long-term care • Non-emergency care when travelling outside - the U.S.	• 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.)		
• Acupuncture – 10 visits per calendar year • Bariatric surgery – 1 procedure per lifetime	• Chiropractic (Manipulative care) • Hearing aids	• Routine eye care (adult) - 1 exam per 1 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 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 1-844-585-1273.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-585-1273.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-585-1273.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-585-1273.

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	$5,000
■ Primary Care copay	$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	10%

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	$5,000
Copayments	$40
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,000**

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

■ The plan's overall deductible	$5,000
■ Specialist copay	$60
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	10%

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	$5,000
Copayments	$1,200
Coinsurance	$50
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$6,280**

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

■ The plan's overall deductible	$5,000
■ Specialist copay	$60
■ Hospital (facility) coinsurance	20%
■ 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*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

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 1-800-368-1019, 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.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

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 ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

st : e l- 0 -f(Ko rea n) A ! § "B .A.l e 9- '2:!O-f ;q .Ai. l::l(.A. ¥li£ O § "? :::L(c. . e 5'lls!J !i!. R QJ'.Ai. (S ummary of Benefits and Coverage, SBC) (7 IAIJ ¥ li * 'c!:l.£.£ * "5 .A 1.2. .

PAUNA\VA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverageo SBC).

BHHMAHHE: 6ecnnaTHl>Ie y cnyrn nepeBo,ila .ilOcryDHl>I,,,,,,,, mo,!leli q, eli p o,!1Ho li .im ,rx .im ID1er c.ii pyccKoM **(R ussian).** Il o3BOHHTe no 6ecnnaTHo My HOMep y Teneq>o Ha, YI<alaHHOMY в ,ilaHHOM « Ofoo pe m.roT H DOI<pl>ITH.ll» (S ummary of Benefits and Coverage, SBC).

<.;W)I ¸ y I j..11 I.>i c _;.w I ..,.iW I L11J..,I] ?'-.J! Jl,....i':11,s>-,), ..ill ti.o<.;.i4-,.I I $.,,,,t.....)\ct..,;, J,,;(Arabic) ¼.Jul uw:i u;5b):"-,l!ii _ \:.,,, (S ummary of Benefits and Covera,ge SBC)

ATANSYON: Si w pale **Kreyol ayisyen (Haitian Creole),** ou kapab benefisye sevis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwotek syon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **franc;ais (F ren ch),** de s services d'aide linguistique vous soot proposes gratuitement. Veuillez appeler le numero sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

U\VAGA: Jezeli m6,visz po **polsku (Polish),** udost pnilismy darmowe uslugi tlumacza. Prosimy zadzwonic pod bezplatny numer podany w niniejszym Zes ta,vieniu s,viadczen i refunda cji (Summary of Benefits and Coverage, SBC).

ATEN<;AO: Se voce fala **portugues (Portuguese),** contate o servic;o de ass is ten cia de idiomas gratuito. Ligue para o numero gratuito listado neste Resumo de Beneficios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia **l'italiano (Italian),** sono disponibili servizi di assistenza linguistica gratuiti. Chiamate ii numero verde indicato all'intemo di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehenlhnen kostenlos sprachliche Hilfsdienstleistungenzur Verfugung. Bitterufen Sie die in dieser Zusammenfassung der Leistungenund Kostenubemahmen (Summary of Benefits and Coverage, SBC) angegebene gebuhrenfreie Rufnummer an.

7.± :t : **B•** **(Japanese)** ii!i :h<Q -g., AA1* 0) i!3'lfi-i1-l::'.A:::·11Jffiv't::t::: t T.
::$: r{* lt:s'J:V:iit{tO)ffil J (Summary of Benefits and Coverage, SBC) .:i c!l½ :h "rv'<Q7 ¹ʃ-
-..;"l"JJ.,. -="[t:s' ii!i \ t::: I,'.

,ywJ! _,y ij.o"-- 0JI _;>,.,.:; fa J$-JI_;.:.,il:i, _;W \.i U_W .,.:;4 <s" W _;1 1_;>J$-JI_; _;.,lo'4 \.ij ab. Id...,,;. u..1**(Farsi) crvU**W J;j p I :.._.;.i .:>,J.>.N <Y'W (Summary of Benefits and Coverage SBC)

t-<!Tof *t :* .3fJq **(Hindi)** *t ,* IITT'!l1 {1j;il<lc'11 . f.=r: R><I> 3 q <'i""-' I °<'1rn Jth. clid :,j (Summary of Benefits and Coverage, SBC) ct T ct c'H {1-"i isl<& GIB .=i.R tl< <!>ti

C EEB T OO M : Yo g k o j h ais Lus **Hmoob (Hmong),** muaj ke v pab txh ais !us pub dawb rau koj. Th ov hu rau tus xov too j hu dawb tee v mua j n yob nta wm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

CH1..mUH'l! M: IU/\JS\il'lS UJ1Wm fiJ1i 1 (K h mer) 1n.1n a w m fiJ1lthWl'll'l l'li rl1:flSM1UlJl'l'1

t\Jl:!ltinJ ls11CU8 i'll'ilti[!)i iclCU1:flSl'lrilITTQll l fl.l06 n.11v UH ll.JlUflclS Sll m fnu61l:l (Summary of Benefits and Coverage, SBC)12:'1

PAKD AAR : Nu saritaem ti Iloca no (Iloca no), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaanpara kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti unegna daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

Dff BAA'A.K O NINIZIN **Dine (Navajo)** bizaad bee yanilti'go, saad bee aka'anida'awo'igii, t'aa jiik'eh, bee na'ah66t'i'. T'aa shqqdi Naaltsoos Bee 'Aa'ahayani d66 Bee 'Ak'e'asti' Bee Baa Hane'i (Summary of Benefits and Coverage, SBC) biyi' t'aa jiik'ehgo beesh bee hane'i bika'igii bee hodiilnih.

O G O \V : Haddii aadku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).