
 **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.whyuhc.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 1-800-444-6222 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | \$0 | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. |
| Are there services covered before you meet your deductible? | No. | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. |
| Are there other deductibles for specific services? | Yes, <u>Prescription drugs</u> -- \$200 per person does not apply to Tier 1 drugs. There are no other <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>? | <u>Network</u> : \$9,200 Individual / \$18,400 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>Premiums</u> , <u>balance-billing</u> charges, 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.whyuhc.com/welcometouhc or call 1-800-444-6222 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 | \$50 copay per visit, deductible does not apply | Not Covered | Virtual visits (Telehealth) - No Charge per visit by a Designated Virtual Network Provider. No virtual coverage for out-of-Network. Under age 19: \$5 copay per visit, deductible does not apply If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery. |
| | Specialist visit | \$100 copay per visit, deductible does not apply | Not Covered | 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 | 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 Lab: \$60 copay per service, deductible does not apply Hospital Lab: \$60 copay per service, deductible does not apply | Not Covered | Designated Network Lab: No Charge |
| | Imaging (CT/PET scans, MRIs) | Free Standing: \$300 copay per service, deductible does not apply Hospital: \$300 copay per service, deductible does not apply | 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) | |
| <p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.whyuhc.com/welcometouhc</p> | Tier 1 | Retail: \$15 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$37.50 <u>copay</u> , <u>deductible</u> does not apply. | Not Covered | <p><u>Provider</u> means pharmacy for purposes of this section.</p> <p>Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply</p> <p>If you use a out of network-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.</p> |
| | Tier 2 | Retail: \$65 <u>copay</u> Mail-Order: \$162.50 <u>copay</u> | Not Covered | <p>You may need to obtain certain drugs, including certain <u>specialty drugs</u>, from a pharmacy designated by us.</p> <p>Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost.</p> <p>Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge.</p> <p>See the website listed for information on drugs covered by your <u>plan</u>. Not all drugs are covered.</p> <p>You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain <u>prescribed drugs</u>.</p> |
| | Tier 3 | Retail: \$95 <u>copay</u> Mail-Order: \$237.50 <u>copay</u> | Not Covered | |
| | Tier 4 | Not Applicable | Not Applicable | Tier not applicable for this <u>plan</u> . |
| <p>If you have outpatient surgery</p> | Facility fee (e.g., ambulatory surgery center) | Ambulatory Surgery Ctr: \$250 <u>copay</u> per service, <u>deductible</u> does not apply Hospital: \$250 <u>copay</u> per service, <u>deductible</u> does not apply | Not Covered | None |
| | Physician/surgeon fees | Ambulatory Surgery Ctr: \$125 <u>copay</u> per visit, <u>deductible</u> does not apply Hospital: \$250 <u>copay</u> per visit, <u>deductible</u> does not apply | 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 | \$1,500 copay per visit, deductible does not apply | \$1,500 copay per visit, deductible does not apply | None |
| | Emergency medical transportation | No Charge | No Charge | None |
| | Urgent care | \$100 copay per visit, deductible does not apply | Not Covered | If you receive services in addition to Urgent Care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$1,500 copay per admission, deductible does not apply | Not Covered | None |
| | Physician/surgeon fees | \$250 copay per visit, deductible does not apply \$1,400 copay per visit, deductible does not apply | Not Covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$100 copay per visit, deductible does not apply | Not Covered | Network partial hospitalization /intensive outpatient treatment/high intensity outpatient: No Charge Under age 19: \$5 copay per visit, deductible does not apply Intensive Behavior Therapy (ABA): No Charge |
| | Inpatient services | \$1,500 copay per admission, deductible does not apply | Not Covered | None |
| If you are pregnant | Office visits | No Charge | Not Covered | Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, deductibles, or coinsurance may apply. |
| | Childbirth/delivery professional services | \$250 copay per visit, deductible does not apply \$1,400 copay per visit, deductible does not apply | Not Covered | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery facility services | \$1,500 copay per admission, deductible does not apply | 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 help recovering or have other special health needs | Home health care | \$100 copay per visit, deductible does not apply | Not Covered | Limited to 40 visits per policy year. |
| | Rehabilitation services | \$100 copay per outpatient visit, deductible does not apply | Not Covered | Limits per policy year: Physical, Speech and Occupational therapy combined limit 60 visits. |
| | Habilitation services | \$100 copay per outpatient visit, deductible does not apply | Not Covered | Limits per policy year: Physical, Speech and Occupational therapy combined limit 60 visits. |
| | Skilled nursing care | \$1,500 copay per admission, deductible does not apply | Not Covered | Unlimited |
| | Durable medical equipment | No Charge | Not Covered | Preauthorization required for DME over \$500 or there is no coverage |
| | Hospice services | \$1,500 copay per admission, deductible does not apply | Not Covered | None |
| If your child needs dental or eye care | Children's eye exam | \$30 copay per visit, deductible does not apply | Not Covered | Limited to 1 exam per 12 month period. Covered for individuals up to the age of 19. |
| | Children's glasses | 50% coinsurance, deductible does not apply | Not Covered | One pair every 12 months. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Covered for individuals up to the age of 19. |
| | Children's dental check-up | 0% coinsurance | Not Covered | Cleanings are covered 2 times per 12 months. Additional limitations may apply. Covered for individuals up to the age of 19. |

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.) | | | |
|---|---|------------------------|--|
| • Acupuncture | • Cosmetic Surgery | • Dental Care (Adult) | |
| • Long-Term Care | • Non-emergency care when travelling outside - the U.S. | • Routine Foot Care | |
| | | • Weight Loss Programs | |

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

- | | | |
|---|------------------------------------|----------------------------|
| • Bariatric Surgery | • Chiropractic (Manipulative) Care | • Hearing aids |
| • Infertility Treatment – Cycle limits may apply. | • Private duty nursing | • Routine Eye Care (Adult) |

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-EBSA (3272) or you may also contact us at 1-800-782-3740. 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, the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the New York Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov/index.htm.

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 1-800-782-3740.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-782-3740.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-782-3740.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-782-3740 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-782-3740.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-782-3740.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-800-782-3740.

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

| | |
|---------------------------------|---------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$100 |
| ■ Hospital (facility) copayment | \$1,500 |
| ■ 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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$1,500 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,560 |

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 copayment | \$100 |
| ■ Hospital (facility) copayment | \$1,500 |
| ■ 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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$700 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$700 |

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

| | |
|---------------------------------|---------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$100 |
| ■ Hospital (facility) copayment | \$1,500 |
| ■ 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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$1,600 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,600 |

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

Notice of Non-Discrimination

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), TTY711, 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 <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (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), TTY711, 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.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 연락하십시오

PAUNAWA: 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 Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

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

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniłmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios 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 il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer 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。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, आपको भाषा सहायता सेवाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री 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 dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនជាអ្នកនិយាយភាសាខ្មែរ (**Khmer**) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខកក់ចេញថ្លៃ ដែលមានកក់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yániit'i'go, saad bee áka'anida'awo'ígíí, t'áá jíílk'eh, bee ná'ahóót'i'. T'áá shqódí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíílk'ehgo béésh bee hane'í biká'ígíí bee hodífilnih.

OGOW: Haddii aad ku 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).