



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 1-866-633-2446 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: \$4,000 Individual / \$8,000 Family 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 deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. <u>Preventive Care Services</u> and categories with a <u>copay</u> are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the annual deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes, Prescription drugs - \$250 Individual/\$500 Family, does not apply to Tier 1 and Tier 2 drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <u>deductibles</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: \$9,100 Individual / \$18,200 Family 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 out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, 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 network provider?	Yes. See www.myuhc.com or call 1-866-633-2446 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 charge</u> 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 referral to see a specialist?	Yes	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
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	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	\$45 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	Not Covered	<p><u>Primary Care Physician</u> must be assigned to member. Primary Care includes <u>network</u> OB/GYNs – no <u>referral</u> required.</p> <p>Under age 19 - Network visits are covered at No Charge.</p> <p>Virtual Visits - No Charge by a Designated Virtual <u>Network Provider</u>. Office Visit cost share applies to any other Telehealth service based on <u>provider</u> type. No <u>referral</u> required.</p> <p>If you receive services in addition to office visit, additional <u>copays</u>, <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.</p>
	<u>Specialist visit</u>	\$70 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	Not Covered	<p>We only accept electronic referrals from the assigned PCP.</p> <p>If you receive services in addition to office visit, additional <u>copays</u>, <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.</p>
	<u>Preventive care/ screening/ immunization</u>	No Charge	Not Covered	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	Diagnostic test (x-ray, blood work)	\$40 <u>copay</u> per service per service, <u>deductible</u> does not apply	\$40 <u>copay</u> per service, <u>deductible</u> does not apply	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$500 <u>copay</u> per service, <u>deductible</u> does not apply	\$500 <u>copay</u> per service, <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 with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at welcometouhc.com	Tier 1 - Your Lowest Cost Option	Retail: \$5 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$12.50 <u>copay</u> , <u>deductible</u> does not apply.	Retail: \$5 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$12.50 <u>copay</u> , <u>deductible</u> does not apply.	Not Covered	<u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail <u>Network</u> Pharmacy. You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. If you use an <u>out-of-network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. <u>Network drug deductible</u> will be applied to the <u>out-of-network provider</u> and applies to the <u>Network out-of-pocket limit</u> .
	Tier 2 - Your Mid-Range Cost Option	Retail: \$50 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$125 <u>copay</u> , <u>deductible</u> does not apply.	Retail: \$50 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$125 <u>copay</u> , <u>deductible</u> does not apply.	Not Covered	
	Tier 3 - Your Mid-Range Cost Option	Retail: \$100 <u>copay</u> Mail-Order: \$250 <u>copay</u>	Retail: \$100 <u>copay</u> Mail-Order: \$250 <u>copay</u>	Not Covered	
	Tier 4 - Your Highest Cost Option	Retail: \$250 <u>copay</u> Mail-Order: \$625 <u>copay</u>	Retail: \$250 <u>copay</u> Mail-Order: \$625 <u>copay</u>	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Not Covered	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	30% <u>coinsurance</u>	Not Covered	Not Covered	None
If you need immediate medical attention	Emergency room care	30% <u>coinsurance</u>	30% <u>coinsurance</u>	*30% <u>coinsurance</u>	\$500 per occurrence <u>deductible</u> applies prior to the overall <u>deductible</u> . * <u>Network deductible</u> applies.
	Emergency medical transportation	30% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Urgent Care	\$75 <u>copay</u> per visit, <u>deductible</u> does not apply	\$75 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not Covered	Not Covered	None
	Physician/surgeon fees	30% <u>coinsurance</u>	Not Covered	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay</u> per visit, <u>deductible</u> does not apply	\$30 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	<u>Network</u> All Other: No Charge. See your policy or <u>plan</u> document for additional information about EAP benefits.
	Inpatient services	30% <u>coinsurance</u>	30% <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	No Charge	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Not Covered	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 facility services	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Not Covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Not Covered	Limited to 60 visits per calendar year.
	<u>Rehabilitation services</u>	\$10 <u>copay</u> per visit, <u>deductible</u> does not apply	\$10 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	Limits per calendar year: Physical, Occupational, Speech, Pulmonary: 20 visits each; Cardiac: 36 visits.
	<u>Habilitative services</u>	\$10 <u>copay</u> per visit, <u>deductible</u> does not apply	\$10 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above. No limits apply for treatment of autism or early childhood intervention.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Not Covered	Limited to 60 days per calendar year, combined with inpatient rehabilitation.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years.
	<u>Hospice services</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	No coverage for Children's eye exams.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
	Children's glasses	Not Covered	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	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.)

- | | | |
|---------------------|--|--|
| • Acupuncture | • Glasses | • Private duty nursing |
| • Bariatric surgery | • Infertility Treatment | • Routine Eye Care |
| • Cosmetic Surgery | • Long Term Care | • Routine foot care - Except as covered for Diabetes |
| • Dental Care | • Non-emergency care when traveling outside - the US | • Weight loss programs |

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

- | | |
|--|----------------|
| • Chiropractic (manipulative) care - 20 visits per calendar year | • 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: 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 or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or Texas Department of Insurance at 1-800-252-3439 or tdi.texas.gov.

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 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-633-2446.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-633-2446 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2446.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2446.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-633-2446.

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$4,000	■ The plan's overall deductible	\$4,000	■ The plan's overall deductible	\$4,000
■ Specialist copay	\$70	■ Specialist copay	\$70	■ Specialist copay	\$70
■ Hospital (facility) coinsurance	30%	■ Hospital (facility) coinsurance	30%	■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%	■ Other coinsurance	30%	■ Other coinsurance	30%
This EXAMPLE event includes services like: Specialist office visits (<i>pre-natal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<u>Cost Sharing</u>		<u>Cost Sharing</u>		<u>Cost Sharing</u>	
Deductibles	\$4,000	Deductibles	\$200	Deductibles	\$2,100
Copayments	\$400	Copayments	\$600	Copayments	\$200
Coinsurance	\$1,800	Coinsurance	\$0	Coinsurance	\$0
<u>What isn't covered</u>		<u>What isn't covered</u>		<u>What isn't covered</u>	
Limits or exclusions	\$60	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$6,260	The total Joe would pay is	\$800	The total Mia would pay is	\$2,300

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