**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, log onto **https://www.myuhc.com** or call 1-844-859-5007 (medical) or 1-855-376-3214 (prescription drug). 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 **https://www.healthcare.gov/sbc-glossary** or call 1-844-859-5007 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$750** Person/**$1,500** Family | 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 policy, 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 services and drugs from the ACA preventive drug list are covered at $0 cost share. | This plan covers some items and services even if you haven't yet met the 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 preventive services at https://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?** | **$3,500** Person / **$7,000** Family | 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, out-of-network charges, balanced-billed 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 **https://www.myuhc.com** or call 1-844-859-5007 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. There is no out-of-network coverage except for emergency care and transportation. |
| **Do you need a referral to see a specialist?** | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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 (Tier 1) | Network Provider (Tier 2) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 copay; $5 copay at Walgreens clinics | 50% coinsurance; $5 copay at Walgreens clinics | $10 copay at clinics other than Walgreens. Check with plan for coverage details on telehealth or virtual visits. Some office visit services may be subject to an additional cost share. No out-of-network coverage. |
| | Specialist visit | $35 copay | 50% coinsurance | Some office visit services may be subject to an additional cost share. No out-of-network coverage. |
| | Preventive care/screening/ immunization | No Charge | No Charge | No out-of-network coverage. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 20% coinsurance | Prior authorization is required for certain services. No out-of-network coverage. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 20% coinsurance | Prior authorization is required for certain services. No out-of-network coverage. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **www.optumrx.com** | Generic drugs | Retail: $5 copay Mail Order: $12 copay | Retail: $5 copay Mail Order: $12 copay | You must meet the deductible. Retail 30-day limit: Lesser of $5 copay or cost of drug. Retail and Mail order: 31–90-day limit: Lesser of $12 copay or cost of drug. All generics will fall into Tier 1. Mail order drugs can be picked up at Walgreens retail stores. No out-of-network coverage. |
| | Preferred brand drugs | Retail: $15 copay Mail Order: $30 copay | Retail: $15 copay Mail Order: $30 copay | You must meet the deductible. Retail 30-day limit: Lesser of $15 copay or cost of drug. Retail and Mail order: 31–90-day limit: Lesser of $30 copay or cost of drug. Mail order drugs can be picked up at Walgreens retail stores. No out-of-network coverage. |
| | Non-preferred brand drugs | Retail: $30 copay Mail Order: $60 copay | Retail: $30 copay Mail Order: $60 copay | You must meet the deductible. Retail 30-day limit: Lesser of $30 copay or cost of |

* For more information about limitations and exceptions, see the plan or policy document at **https://www.myuhc.com**.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (Tier 1) | Network Provider (Tier 2) | |
| | | | | drug.<br>Retail and Mail order: 31–90-day limit: Lesser of $60 copay or cost of drug. Mail order drugs can be picked up at Walgreens retail stores.<br>No out-of-network coverage. |
| | Specialty drugs | Covered under Generic, Non-preferred, and Preferred as detailed above. | Covered under Generic, Non-preferred, and Preferred as detailed above. | No out-of-network coverage. Certain specialty prescription drugs may be subject to a separate cost share. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Hospital Tiering: $500 copay and 50% coinsurance<br>No Hospital Tiering: 20% coinsurance | Hospital Tiering in select markets. Required use of Centers of Excellence for certain conditions. Check plan for details. Prior authorization is required for certain services. No out-of-network coverage. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | No out-of-network coverage. Hospital Tiering in select markets. Prior authorization is required for certain services. Check plan for details. |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance | Non-emergency use of the emergency room is not covered. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Non-emergency use of emergency medical transportation is not covered. |
| | Urgent care | 20% coinsurance | 20% coinsurance | No out-of-network coverage. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Hospital Tiering: $500 copay and 50% coinsurance<br>No Hospital Tiering: 20% coinsurance | Hospital Tiering in select markets. Required use of Centers of Excellence for certain conditions. Check plan for details. Prior authorization is required for certain services. No out-of-network coverage. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | Hospital Tiering in select markets. Required use of Centers of Excellence for certain conditions. Check plan for details. Prior authorization is required for certain services. No out-of-network coverage. |
| **If you need mental health, behavioral** | Outpatient services | $20 copay | $20 copay | Copays apply before deductible is met. Full price varies per behavioral health fee schedule. Check |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (Tier 1) | Network Provider (Tier 2) | |
| **health, or substance abuse services** | | | | with plan for coverage details on telehealth or virtual visits. No out-of-network coverage. |
| | Inpatient services | 20% coinsurance | 20% coinsurance | Check plan for details and limits. No out-of-network coverage. |
| **If you are pregnant** | Office visits | $20 copay | 50% coinsurance | Charge only for initial visit to confirm pregnancy. No out-of-network coverage. |
| | Childbirth/delivery professional services | 20% coinsurance | Hospital Tiering: 50% coinsurance<br>No Hospital Tiering: 20% coinsurance | Hospital Tiering in select markets. Fertility services have lifetime limits of $25,000 (medical) and $15,000 (prescription drug). Prior authorization is required for certain services. Required use of Centers of Excellence for certain conditions for BCBS. Check plan for details and limits. No out-of-network coverage. |
| | Childbirth/delivery facility services | 20% coinsurance | Hospital Tiering: $500 copay and 50% coinsurance<br>No Hospital Tiering: 20% coinsurance | Hospital Tiering in select markets. Fertility services have lifetime limits of $25,000 (medical) and $15,000 (prescription drug). Prior authorization is required for certain services. Required use of Centers of Excellence for certain conditions for BCBS. No out-of-network coverage. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 20% coinsurance | Check plan for limits. No out-of-network coverage. |
| | Rehabilitation services | 20% coinsurance | 20% coinsurance | 60 combined visits for speech, occupational, and physical therapies. No out-of-network coverage. |
| | Habilitation services | 20% coinsurance | 20% coinsurance | 60 combined visits for speech, occupational, and physical therapies. No out-of-network coverage. |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance | Check plan for limits. No out-of-network coverage. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | Check plan for limits. No out-of-network coverage. |
| | Hospice services | 20% coinsurance | 20% coinsurance | Check plan for limits. No out-of-network coverage. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | No out-of-network coverage. |
| | Children's glasses | Not covered | Not covered | No out-of-network coverage. |
| | Children's dental check-up | Not covered | Not covered | No out-of-network coverage. |

## 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 (Adult)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult and Child)
- Routine foot care (with the exception of person with diagnosis of diabetes)
- Weight loss program

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

- Acupuncture
- Bariatric surgery
- Hearing aids
- Infertility treatment
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the United States

**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.hhs.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: 1-844-859-5007 or visit **https://www.myuhc.com**. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at **https://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Consumer-Assistance-Program-Grants.html**.

**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 1-844-859-5007.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-859-5007.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-859-5007.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-859-5007.

*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 **https://www.myuhc.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 | $750 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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:** | |
| *Cost Sharing* | |
| Deductibles | $750 |
| Copayments | $0 |
| Coinsurance | $750 |
| *What isn't covered* | |
| 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 | $750 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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:** | |
| *Cost Sharing* | |
| Deductibles | $750 |
| Copayments | $400 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,270** |

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

| | |
|---|---|
| The plan's overall deductible | $750 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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:** | |
| *Cost Sharing* | |
| Deductibles | $750 |
| Copayments | $100 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,150** |

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