




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 either <https://www.myuhc.com> or www.bcbsil.com/walgreens, as applicable, or call 1-844-859-5007 (UHC) or 1-800-247-9207 (BCBS) or 1-855-376-3214 (OptumRx). 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 (UHC) or 1-800-247-9207 (BCBS) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$3,000 Person / \$6,000 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 ?	\$6,000 Person / \$12,000 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 or www.bcbsil.com/walgreens or call 1-800-247-9207, as applicable, 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	Yes, for UHC Navigate network only.	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 [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	\$20 copay; \$5 copay at Walgreens clinics	Not covered	Copays apply before deductible is met. \$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 .
	Specialist visit	\$35 copay	Not covered	Copays apply before deductible is met. Some office visit services may be subject to an additional cost share . Participants in UHC Navigate network need a specialist referral from their primary care physician.
	Preventive care/screening/immunization	No charge	Not covered	Check plan for details and limits.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	Preauthorization is required for certain services.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Preauthorization is required for certain services.
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	Not covered	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.
	Preferred brand drugs	Retail: \$25 copay Mail Order: \$50 copay	Not covered	If you choose a brand name drug when a generic is available, you may be required to pay the brand name cost plus a penalty. Retail 30-day limit: Lesser of \$25 copay or cost of drug. Retail and Mail order: 31–90-day limit: Lesser of

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.myuhc.com> or www.bcbsil.com/walgreens. **Page 2 of 6**

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)	
				\$50 copay or cost of drug. Mail order drugs can be picked up at Walgreens retail stores.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Non-preferred brand drugs	Retail: \$50 copay Mail Order: \$100 copay	Not covered	If you choose a brand name drug when a generic is available, you may be required to pay the brand name cost plus a penalty. Retail 30-day limit: Lesser of \$50 copay or cost of drug. Retail and Mail order: 31–90-day limit: Lesser of \$100 copay or cost of drug. Mail order drugs can be picked up at Walgreens retail stores.
	Specialty drugs	Covered under Generic, Non-preferred, and Preferred as detailed above.	Not covered	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	Not covered	Preauthorization is required for certain services.
	Physician/surgeon fees	20% coinsurance	Not covered	Preauthorization is required for certain services.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Preauthorization is required for certain services.
	Physician/surgeon fees	20% coinsurance	Not covered	Required use of Centers of Excellence for certain conditions. Check plan for details. Prior authorization is required for certain services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 office visit copay	Not covered	Copays apply before deductible is met. Full price varies per behavioral health fee schedule. Check with plan for coverage details on telehealth or virtual visits.
	Inpatient services	20% coinsurance	Not covered	None
If you are pregnant	Office visits	\$20 copay	Not covered	Charge only for initial visit to confirm pregnancy.

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)	
	Childbirth/delivery professional services	20% coinsurance	Not covered	Additional cost share may apply for a newborn whose length of stay exceeds the standard range for a normal delivery. Fertility services have lifetime limits of \$50,000 (medical) and \$15,000 (prescription drug). Preauthorization is required for certain services.
	Childbirth/delivery facility services	20% coinsurance	Not covered	Additional cost share may apply for a newborn whose length of stay exceeds the standard range for a normal delivery. Fertility services have lifetime limits of \$50,000 (medical) and \$15,000 (prescription drug). Preauthorization is required for certain services.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Check plan for details and limits.
	Rehabilitation services	20% coinsurance	Not covered	60 combined visits for speech, occupational, and physical therapies.
	Habilitation services	20% coinsurance	Not covered	60 combined visits for speech, occupational, and physical therapies.
	Skilled nursing care	20% coinsurance	Not covered	Check plan for details and limits.
	Durable medical equipment	20% coinsurance	Not covered	Check plan for details and limits.
	Hospice services	20% coinsurance	Not covered	Check plan for details and limits.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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: UnitedHealthcare at 1-844-859-5007 or visit <https://www.myuhc.com> or Blue Cross Blue Shield of Illinois at 1-800-247-9207 or visit www.bcbsil.com/walgreens, as applicable, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. 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 (UHC) or 1-800-247-9207 (BCBS).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-859-5007 (UHC) or 1-800-247-9207 (BCBS).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-859-5007 (UHC) or 1-800-247-9207 (BCBS).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-844-859-5007 (UHC) or 1-800-247-9207 (BCBS).

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](#) \$3,000
- [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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$10
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,970

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$3,000
- [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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$300
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,400

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$3,000
- [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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.