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 these websites*. For 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-(855) 472-7778.**

Important Questions	Answers	Why This Matters
What is the overall deductible?	$0	See the Common Medical Events chart below for a partial list of costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes	There is no deductible, but a copayment may apply. For example, this plan covers certain preventive services without cost-sharing. 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 covered services.
What is the out-of-pocket limit for this plan?	For network providers: $6,000 individual / $12,000 family For out-of-network providers: $12,000 individual / $24,000 family	The out-of-pocket limit is the most you could pay in a plan year for covered services. Copayments for covered health care services, **including for conditional coverage† tests and treatments,** and copayments for covered prescriptions, count toward your out-of-pocket limit. 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.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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.

* During open enrollment, visit choosebind.com/uhg and use access code: **UHG2021**. After you enroll, see the plan documents, download the MyBind app, visit the MyBind.com website, or call Bind Help for more detailed coverage information, including without limitation a specific copayment for a specific service, plan limitations and exceptions, and other important cost and coverage information.

† Once enrolled, the plan includes the right to elect conditional coverages into your benefit package for certain less-common tests and treatments too numerous to describe in this summary if you have an adverse health factor – a new or deteriorating medical condition that coincides with the conditional coverage you need. Conditional coverage tests and treatments must first be activated by you before coverage is effective under the plan; copayment for conditional coverages may vary from those listed in this summary. See the plan document, visit one of the Bind websites listed in the footnote on Page 1, go to the MyBind app, or call Bind Help for assistance.

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	$10 - $85 copayment/visit	$160 copayment/visit	Certain procedures performed in the office may have a higher copayment. Virtual visit – network providers no copayment or deductible No coverage from out-of-network providers for virtual visit. Certain **conditional coverage† tests and treatments** must first be activated by you before coverage is effective under the plan.
	Specialist visit	$10 - $85 copayment/visit	$160 copayment/visit	
	Preventive care/screening/ immunization	No charge	$120 copayment/visit	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 (e.g. x-ray, blood work)	No charge	No charge	Higher copayments apply to genetic testing and **conditional coverage†**. Certain **conditional coverage† tests and treatments** must first be activated by you before coverage is effective under the plan.
	Imaging (CT/PET scans, MRIs)	$200 - $700 copayment/visit	$1,400 copayment/visit	Multiple copayments may apply if more than one body part is scanned during a visit. Higher copayments apply to genetic testing. Preauthorization is required for certain imaging tests or may not be covered.

‡ The full range of copayment may not be available in all areas or for all services.

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† Once enrolled, the plan includes the right to elect conditional coverages into your benefit package for certain less-common tests and treatments too numerous to describe in this summary if you have an adverse health factor – a new or deteriorating medical condition that coincides with the conditional coverage you need. Conditional coverage tests and treatments must first be activated by you before coverage is effective under the plan; copayment for conditional coverages may vary from those listed in this summary. See the plan document, visit one of the Bind websites listed in the footnote on Page 1, go to the MyBind app, or call Bind Help for assistance.

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 More information about **prescription drug coverage** is available at one of the Bind websites listed in the footnote on page 1.	**Tier 1 drugs**	**34-Day Supply** $15 copayment retail **90-Day Supply** $35 copayment Mail Order	Not covered	Certain Tier 1 drugs are available with $0 copayments, including prescribed generic contraceptives and tobacco cessation medications. To learn more about drug tiers and about copayments for specific drugs, visit one of the Bind websites listed in the footnote on page 1. Preauthorization is required for certain drugs or may not be covered.
	Tier 2 drugs	**34-Day Supply** $40 copayment retail **90-Day Supply** $90 copayment Mail Order	Not covered	
	Tier 3 drugs	**34-Day Supply** $85 copayment retail **90-Day Supply** $190 copayment Mail Order	Not covered	
	Tier 4 drugs	**30-Day Supply** $300 copayment retail **90-Day Supply** $750 copayment Mail Order	Not covered	You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Specialty drugs – No grace fills at Retail Preauthorization is required for certain Specialty drugs or may not be covered.

‡ The full range of copayment may not be available in all areas or for all services.
* During open enrollment, visit choosebind.com/uhg and use access code: **UHG2021**. After you enroll, see the plan documents, download the MyBind app, visit the MyBind.com website, or call Bind Help for more detailed coverage information, including without limitation a specific copayment for a specific service, plan limitations and exceptions, and other important cost and coverage information.

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 have outpatient surgery	Facility access (e.g., ambulatory surgery center)	Up to $2,200 copayment/visit	Up to $4,400 copayment/visit	Copayments are based on provider, procedure/service, and service location. Preauthorization is required for certain outpatient surgery or may not be covered. Certain **conditional coverage† tests and treatments** must first be activated by you before coverage is effective under the plan.
	Physician/surgeon fees	Included in the facility copayment	Included in the facility copayment	
If you need immediate medical attention	Emergency room care	$400 copayment/visit	$400 copayment/visit	Copayment is waived if admitted within 24 hours.
	Emergency medical transportation	$500 copayment/transport	$500 copayment/transport	Preauthorization is required for non-Emergency ground/air Ambulance or services not covered.
	Urgent care	$150 copayment/visit	$300 copayment/visit	None
If you have a hospital stay	Facility access (e.g., hospital room)	Up to $2,600 copayment/stay	Up to $4,700 copayment/stay	Copayments are based on provider, procedure/service, and service location. Multiple copayments may apply if more than one procedure is done during a visit. Preauthorization is required for non-emergency facility admissions and inpatient surgery or may not be covered. Multiple copayments may apply if more than one planned major surgery is done during the stay. Certain **conditional coverage† tests and treatments** must first be activated by you before coverage is effective under the plan.
	Physician/surgeon services	Included in the facility copayment	Included in the facility copayment	

‡ The full range of copayment may not be available in all areas or for all services.
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† Once enrolled, the plan includes the right to elect conditional coverages into your benefit package for certain less-common tests and treatments too numerous to describe in this summary if you have an adverse health factor – a new or deteriorating medical condition that coincides with the conditional coverage you need. Conditional coverage tests and treatments must first be activated by you before coverage is effective under the plan; copayment for conditional coverages may vary from those listed in this summary. See the plan document, visit one of the Bind websites listed in the footnote on Page 1, go to the MyBind app, or call Bind Help for assistance.

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 mental health, behavioral health, or substance abuse services	Outpatient services	**Home/Office**: $10 copayment/visit **Outpatient Hospital**: Up to $1,000 copayment/visit	**Home/Office**: $120 copayment/visit **Outpatient Hospital**: Up to $2,000 copayment/visit	Certain procedures/services in the outpatient setting may have a lower copayment. Preauthorization is required for certain outpatient services or may not be covered.
	Inpatient services	$1,500 copayment/stay	$3,000 copayment/stay	Preauthorization is required for certain inpatient services or may not be covered.
If you are pregnant	Routine pre- and post-natal office visits	No charge	$120 copayment/visit	Cost sharing does not apply to preventive services with network providers.
	Childbirth/delivery professional services	Included in the facility copayment	Included in the facility copayment	One copayment for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother.
	Childbirth/delivery facility services	$500 - $1,500 copayment/stay	$3,000 copayment/stay	
If you need help recovering or have other special health needs	Home health care	$25 copayment/visit	$160 copayment/visit	Visit Limit: 60 for Home health care per person per plan year (visit limits are a combination of network providers and out-of-network providers) Preauthorization is required for certain home health care services or may not be covered.
	Rehabilitation services	$15 - $35 copayment/visit	$90 copayment/visit	Visit limits per person per plan year, are a combination of network providers and out-of-network providers. 60 visit limit for physical therapy and occupational therapy, 90 visit limit for speech therapy 36 visit limit for cardiac rehab 20 visit limit for pulmonary rehab Cardiac Rehab and Pulmonary Rehab: $40 copayment network providers $80 copayment out-of-network providers.
	Habilitation services	$15 - $35 copayment/visit	$90 copayment/visit	

‡ The full range of copayment may not be available in all areas or for all services.
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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	Skilled nursing care	$1,400 copayment/stay	$2,800 copayment/stay	Visit Limit: 120 days for Skilled nursing care per person per plan year. (the day limit is a combination of network providers and out-of-network providers)
	Durable medical equipment (DME)	$0 - $1,000 copayment/ equipment based on DME tier	$20 - $2,000 copayment/ equipment based on DME tier	For DME tiers and limitations, visit one of the Bind websites listed in the footnote on page 1. Preauthorization is required for certain DME or may not be covered.
	Hospice services	**Home**: $25 copayment **Inpatient**: $1,500 copayment/stay	**Home**: $160 copayment **Inpatient**: $3,000 copayment/stay	Preauthorization is required for certain hospice services or may not be covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

‡ The full range of copayment may not be available in all areas or for all services.
* During open enrollment, visit choosebind.com/uhg and use access code: **UHG2021**. After you enroll, see the plan documents, download the MyBind app, visit the MyBind.com website, or call Bind Help for more detailed coverage information, including without limitation a specific copayment for a specific service, plan limitations and exceptions, and other important cost and coverage information.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Bariatric surgery
- Dental care (routine)
- Infertility treatment
- Long term care
- Private duty nursing
- Routine eye care (Adult)

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

- Acupuncture (10 visit limit per person per plan year)
- Applied Behavioral Analysis (ABA)
- Chiropractic care (20 visit limit per person per plan year)
- Forty-four (44) other **conditional coverage† tests and treatments** that must first be activated in advance for the coverage to be effective.
- Hearing aids (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine foot care (for certain conditions)
- Weight loss programs

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 the agency is the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: Bind at 1-(855) 472-7778; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace of other individual market policies, Medical, 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-(855) 472-7778.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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	$0
Hospital (facility) copayment	$1,500
Other copayments	$280

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	$0
Copayments	$1,780
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,800**

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	$160
Hospital (facility) copayment	$0
Other copayments	$1,740

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	$0
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,900**

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

The plan's overall deductible	$0
Specialist copayment	$160
Hospital (facility) copayment	$400
Other copayments	$640

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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

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, 6 a.m. to 7 p.m. CST

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, 6 a.m. to 7 p.m. CST

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 전화하십시오.

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).

العربية تنبيه: إذا كنت تتحدث **(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 benefisye 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)**, udostępniliśmy 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 द: यद आप हदं (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, न:शुल्क उपलब्ध ह। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सचू ीबद्ध टोल फ्र नंबर पर कॉल कर

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.

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 yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayáníí dóó Bee 'Ak'é'asti' Bee Baa Hane'íí (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'íí bika'ígíí bee hodíilnih.

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).