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.welcometouhc.com or by calling 1-800-782-3740. 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: $100 Individual / $300 Family out-of-Network: $100 Individual / $300 Family Per calendar year.	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 plan, 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 is covered before you meet your deductible.	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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, Prescription drugs - $200 Individual/ $400 Family There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: $2,500 Individual / $7,500 Family out-of-Network: $2,500 Individual / $7,500 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, balance-billing charges (unless balanced billing is prohibited), health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	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 www.welcometouhc.com or call 1-800-782-3740 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. 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.

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% coinsurance, deductible does not apply	30% coinsurance	Virtual visits (Telehealth) - 10% coinsurance by a Designated Virtual Network Provider, deductible does not apply.
	Specialist visit	10% coinsurance, deductible does not apply	30% coinsurance	None
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. 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)	10% coinsurance, deductible does not apply	30% coinsurance	Preauthorization required for certain services or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	10% coinsurance, deductible does not apply	30% coinsurance	Preauthorization required or benefit reduces to 50% of allowed.

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 www.welcometouhc.com	Tier 1 - Your Lowest-Cost Option	Retail: $10 copay Mail-Order: $30 copay	Retail: $10 copay	Provider 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 Network pharmacy. If you use an out-of-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Prescription drug List (PDL): Advantage . Network: National. . If a dispensed drug has a chemically equivalent drug, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Certain preventive medications, zero cost share medications, and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: $30 copay Mail-Order: $90 copay	Retail: $30 copay	
	Tier 3 - Your Midrange-Cost Option	Retail: 50% coinsurance Mail-Order: 50% coinsurance	Retail: 50% coinsurance	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance, deductible does not apply	30% coinsurance	Preauthorization required for certain services or benefit reduces to 50% of allowed.
	Physician/surgeon fees	10% coinsurance, deductible does not apply	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance, deductible does not apply	10% coinsurance, deductible does not apply	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	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)	
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance, deductible does not apply	30% coinsurance	Preauthorization required or benefit reduces to 50% of allowed.
	Physician/surgeon fees	10% coinsurance, deductible does not apply	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance, deductible does not apply	30% coinsurance	Network partial hospitalization /intensive outpatient treatment: 10% coinsurance, deductible does not apply Preauthorization required for certain services or benefit reduces to 50% of allowed.
	Inpatient services	10% coinsurance, deductible does not apply	30% coinsurance	Preauthorization required or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	30% coinsurance	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	10% coinsurance, deductible does not apply	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery facility services	10% coinsurance, deductible does not apply	30% coinsurance	Inpatient preauthorization apply if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed.
If you need help recovering or have other special health needs	Home health care	10% coinsurance, deductible does not apply	30% coinsurance	Limited to 60 visits per calendar year. Preauthorization required or benefit reduces to 50% of allowed.
	Rehabilitation services	10% coinsurance, deductible does not apply	30% coinsurance	Limits per calendar year: Physical, Occupational, Speech: Unlimited. Pulmonary: 20 visits; Cardiac: 36 visits.

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)	
	Habilitation services	10% coinsurance, deductible does not apply	30% coinsurance	Limits per calendar year: Physical, Occupational, Speech: Unlimited. Cost share applies for outpatient services only. Preauthorization required inpatient services or benefit reduces to 50% of allowed.
	Skilled nursing care	10% coinsurance, deductible does not apply	30% coinsurance	Skilled Nursing Facility is limited to 60 days per calendar year (combined with Inpatient Rehabilitation) . Preauthorization required or benefit reduces to 50% of allowed.
	Durable medical equipment	10% coinsurance	30% coinsurance	Covers 1 per type of Durable medical equipment (including repair/replace) every 3 years. Preauthorization required Durable medical equipment over $1,000 or no coverage.
	Hospice services	No Charge	30% coinsurance	Preauthorization required before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam	No Charge	30% coinsurance	One exam every 12 months.
	Children's glasses	$25 copay per frame, deductible does not apply	30% coinsurance	One pair every 12 months. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit does not cover both.
	Children's dental check-up	No Charge	No Charge	Cleanings covered 2 times per 12 months.

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)		
• Chiropractic care-24 visits per calendar year	• Hearing aids	• 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: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration, 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: 1-800-782-3740 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Hawaii Department of Commerce & Consumer Affairs at 808-586-2804 or www.hawaii.gov/dcca/ins.

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 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 .
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740 .
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-782-3740 .
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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** **$ 100**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$100
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,260**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$ 100**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$100
Copayments	$700
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$890**

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

- **The plan's overall deductible** **$ 100**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$100
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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), TTY 711, 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 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, 8 a.m. to 8 p.m.

ATENCION: Si habla **espafiol (Spanish),** hay servicios de asistencia de idiomas, sin cargo, a su disposici6n. Llame al numero gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

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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).

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

UWAGA: Jezeli m6wisz po **polsku (Polish),** udostypnilismy darmowe uslugi thtmacza. Prosimy zadzwonic pod bezplatny numer podany w niniejszym Zestawieniu swiadczen i refundacji (Summary of Benefits and Coverage, SBC).

ATEN<;AO: Se voce fala **portugues (Portuguese),** contate o servi90 de assistencia de idiomas gratuito. Ligue para o nu.mere gratuito listado neste Resumo de Beneficios 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 alfinterno 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 Verfugung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenubernahmen (Summary of Benefits and Coverage, SBC) angegebene gebiihrenfreie Rufnummer an.

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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).

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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).