# Summary of Benefits and Coverage

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 1-877-706-1739 or visit [welcometouhc.com](http://welcometouhc.com). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-866-487-2365 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
</table>
| What is the overall deductible?                          | **Network:** $2,000 Individual / $4,000 Family  
**Non-Network:** $3,000 Individual / $6,000 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 policy, the overall family deductible must be met before the plan begins to pay. The plan has a combined deductible for medical and pharmacy. |
| 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 annual 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 services at [www.healthcare.gov/coverage/preventive-care-benefits/](http://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?           | **Network:** $4,000 Individual / $8,000 Family  
**Non-Network:** $6,000 Individual / $12,000 Family  
Per calendar year.  | 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, the overall family out-of-pocket limit must be met. The plan has a combined medical and pharmacy out of pocket limit. |
| What is not included in the out-of-pocket limit?          | Premiums, balance-billing charges, 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 [myuhc.com](http://myuhc.com) or call 1-877-706-1739 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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Non-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/Immunization</td>
<td>No Charge</td>
<td>40% <strong>coinsurance</strong></td>
</tr>
</tbody>
</table>
| If you have a test | Diagnostic test (x-ray, blood work) | Free Standing/Office: 20% **coinsurance**
Hospital: 40% **coinsurance** | 40% **coinsurance** | Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount. |
|                      | Imaging (CT/PET scans, MRIs) | Free Standing/Office: 20% **coinsurance**
Hospital: 40% **coinsurance** | 40% **coinsurance** | Preauthorization is required non-network or benefit reduces to 50% of allowed amount. |
| If you need drugs to treat your illness or condition | Generic drugs | Retail: 20% **co-ins** after ded
Mail order: 20% **co-ins** after ded | Retail: 40% **co-ins after ded**
Mail order: 40% **co-ins after ded** | Provider means pharmacy for purposes of this section. The deductible is combined with the medical deductible. Retail: Up to a 31 day supply. Mail order: Up to a 90 day supply. Prior authorization, pre-notification, and quantity limits apply to certain drug classes. This plan utilizes the Maintenance Choice Prescription Program (MChoice) which requires those members with ongoing prescriptions to use a 90-day mail order prescription after the third 30-day fill. (Specialty drugs are not eligible for MChoice). The out of pocket limit is combined for medical and pharmacy. |
|                      | Preferred brand drugs | Retail: 20% **co-ins** after ded
Mail order: 20% **co-ins** after ded | Retail: 40% **co-ins after ded**
Mail order: 40% **co-ins after ded** |
|                      | Non-preferred brand drugs | Retail: 20% **co-ins** after ded | Retail: 40% **co-ins after ded** |

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.
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<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Non-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Specialty drugs</td>
<td>Mail order: 20% co-ins after ded</td>
<td>Mail order: 40% co-ins after ded</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td>*20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>*20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
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<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>20% coinsurance 40% coinsurance</td>
<td>Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance 40% coinsurance</td>
<td>Preauthorization is required non-network or benefit reduces to 50% of allowed amount.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No Charge 40% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance 40% coinsurance</td>
<td>Inpatient preauthorization applies non-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance 40% coinsurance</td>
<td>Inpatient preauthorization applies non-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance 40% coinsurance</td>
<td>Limited to 100 visits per calendar year. Preauthorization is required non-network or benefit reduces to 50% of allowed amount.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance 40% coinsurance</td>
<td>Limits per calendar year: Physical, Speech, Occupational: combined limit 60 visits; Cardiac: 36 visits; Pulmonary: 20 visits. Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount.</td>
</tr>
<tr>
<td></td>
<td>Habilitative services</td>
<td>20% coinsurance 40% coinsurance</td>
<td>Services are provided under and limits are combined with Rehabilitation Services above. Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance 40% coinsurance</td>
<td>Limited to 100 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required non-network or benefit reduces to 50% of allowed amount.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance 40% coinsurance</td>
<td>Preauthorization is required non-network for DME over $1,000 or no coverage.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance 40% coinsurance</td>
<td>Preauthorization is required non-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>20% coinsurance</td>
<td>40% coinsurance Limit to once every 24 months.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not Covered</td>
<td>Not Covered No coverage for Children's glasses.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>Not Covered No coverage for Children's Dental check-up.</td>
</tr>
</tbody>
</table>

**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.):**

- Bariatric surgery
- Cosmetic surgery
- Dental care
- Glasses
- Hearing aids
- Infertility and Fertility treatment
- Long-term care
- Routine foot care – Except as covered for Diabetes
- Weight loss programs-Except as covered for Diabetes and Real Appeal

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

- Acupuncture – 20 visits per calendar year
- Chiropractic (Manipulative care) – 60 visits per calendar year
- Non-emergency care when travelling outside - the U.S.

**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 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.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage?** Yes

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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:
Navajo (Dine): Dine\'ehgo shika a\'ohwol ninisingo, kwijijgo holne 1-877-706-1739.

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: $2,000
- Specialist coinsurance: 20%
- 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: $12,800

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

- The plan’s overall deductible: $2,000
- Specialist coinsurance: 20%
- 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: $7,400

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

- The plan’s overall deductible: $2,000
- Specialist coinsurance: 20%
- 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: $1,900

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.
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, 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.

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 LUÚ Y: 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 đại thể bảo hiểm (Summary of Benefits and Coverage, SBC) này.
ALARM: 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 nagasalita 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 Benepisyos at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чьей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisyè sev ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantage 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 Benefizi 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。
Summary of Benefits and Coverage, SBC

To get a copy of the Summary of Benefits and Coverage (SBC) in Farsi, please contact the Service Center or visit their website. The SBC provides information about the benefits and coverage available to you.

CEEB TOOM: Yog koy hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koy. 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.

PAAKDAAR: 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 yániti'i go, saad bee áka'anida'awo'igii, t'áá jiik'eh, bee ná'ahóóti'i. Táá shoqdi Naaltsoos Bee 'Aa'hayání dóó Bee 'Ak'éasti' Bee Baa Hane'i (Summary of Benefits and Coverage, SBC) biyi' t'áá jiik'ehgo béesh bee hane'i biká'igii bee hodílnih.

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).