



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-844-4999.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$4,000 single / \$4,000 2 or more individuals (family) Per Calendar Year. Doesn't apply to covered preventive care and other services listed as "No Charge". Out-of-Network Not Covered.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The deductible starts over each January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No. 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.
Is there an out-of-pocket limit on my expenses?	Yes for participating providers \$6,850 individual / \$12,000 family. Includes deductible, co-pays & co-insurance	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, health care this plan doesn't cover, and out-of-network charges.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes, this plan uses network providers. If you use non-network providers you are responsible for 100% of the cost. For a list of participating providers, visit www.myuhc.com or call 1-877-844-4999.	If you use a network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the Common Medical Events chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No. You don't need a referral to see a specialist .	You can see an in-network specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

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- **Co-payments** are fixed dollar amounts (for example, \$50) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 10% would be \$100. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a **provider** charges \$1,500 for a medical service and the allowed **amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan **requires** you to use participating or in-network **providers**.
- **This plan does not cover non-network providers or services.**

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% co-insurance after deductible met	Not Covered	If you receive services in addition to office visit, additional deductible or co-insurance may apply. No coverage non-network.
	Specialist visit	10% co-insurance after deductible met	Not Covered	If you receive services in addition to office visit, additional deductible or co-insurance may apply. No coverage non-network.
	Other practitioner office visit – Manipulative (Chiropractic) services	10% co-insurance after deductible met	Not Covered	Limited to 20 visits of Manipulative (Chiropractic) services per calendar year. No coverage non-network.
	Preventive care/screening/immunization	No charge	Not Covered	Includes preventive health services specified in the health care reform law. No coverage non-network.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance after deductible met	Not Covered	No coverage non-network.
	Imaging (CT/PET scans, MRIs)	10% co-insurance after deductible met	Not Covered	No coverage non-network.

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If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myuhc.com .	Tier 1 – Your Lowest-Cost Option	10% co-insurance After Deductible Met	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. The co-insurance for prescription drugs apply to the out-of-pocket limit . No coverage non-network.
	Tier 2 – Your Mid-Range Cost Option	10% co-insurance After Deductible Met	Not Covered	
	Tier 3 – Your Highest-Cost Option	10% co-insurance After Deductible Met	Not Covered	
	Tier 4 – Additional High-Cost Option	10% co-insurance After Deductible Met	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance after deductible met	Not Covered	No coverage non-network.
	Physician/surgeon fees	10% co-insurance after deductible met	Not Covered	No coverage non-network.
If you need immediate medical attention	Emergency room services	\$250 co-pay per visit after deductible met	\$250 co-pay per visit after deductible met	Notification is required if confined in a non-Network Hospital.
	Emergency medical transportation	10% co-insurance after deductible met	10% co-insurance	Notification is required if confined in a non-Network Hospital
	Urgent care	\$50 co-payment per visit after deductible met	Not Covered	If you receive services in addition to urgent care, additional deductibles, or co-insurance may apply. No coverage non-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance after deductible met	Not Covered	No coverage non-network.

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	Physician/surgeon fee	10% co-insurance after deductible met	Not Covered	No coverage non-network.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% co-insurance after deductible met	Not Covered	See your policy or plan document for additional information about EAP benefits. No coverage non-network.
	Mental/Behavioral health inpatient services	10% co-insurance after deductible met	Not Covered	See your policy or plan document for additional information about EAP benefits. No coverage non-network.
	Substance use disorder outpatient services	10% co-insurance after deductible met	Not Covered	See your policy or plan document for additional information about EAP benefits. No coverage non-network.
	Substance use disorder inpatient services	10% co-insurance after deductible met	Not Covered	See your policy or plan document for additional information about EAP benefits. No coverage non-network.
If you are pregnant	Prenatal and postnatal care	10% co-insurance after deductible met	Not Covered	Network routine pre-natal care is covered at No Charge. No coverage non-network.
	Delivery and all inpatient services	10% co-insurance after deductible met	Not Covered	Additional co-pays, deductibles or co-insurance may apply. No coverage non-network.
If you need help recovering or have other special health needs	Home health care	10% co-insurance after deductible met	Not Covered	Limited to 60 visits per calendar year. (1 visit equals up to 4 hours of skilled care services) No coverage non-network.
	Rehabilitation services	10% co-insurance after deductible met	Not Covered	Depending on the type of therapy, there is a limit of 60 visits per calendar year. No coverage non-network.

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	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation services.
	Skilled nursing care	10% co-insurance after deductible met	Not Covered	Limited to 60 days per calendar year. No coverage non-network.
	Durable medical equipment	10% co-insurance after deductible met	Not Covered	\$5,000 maximum per calendar year if the benefit/device is determined to be non-essential. Covers 1 per type of DME (including repair/replacement) every 3 years. No coverage non-network.
	Hospice service	10% co-insurance after deductible met	Not Covered	No coverage non-network.
If your child needs dental or eye care	Eye exam	10% co-insurance after deductible met	Not Covered	Limited to 1 exam every other calendar year.
	Glasses	Not Covered	Not Covered	No coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Acupuncture (if prescribed for rehabilitation purposes) • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Glasses • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care • Weight loss programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> • Chiropractic care– may be covered with limitations 	<ul style="list-style-type: none"> • Hearing aids– may be covered with limitations 	<ul style="list-style-type: none"> • Routine eye care (Adult) – may be covered with limitations

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.

若需要中文协助，请拨打您会员卡上的电话号码

Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniye nanitinigii number bika'igii bich'i' hodiilnih

Para sa tulong sa Tagalog, tawagan ang numero sa iyong

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

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$3,040
- Patient pays \$4,500

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$4,000
Co-pays	\$0
Co-insurance – 10%	\$300
Limits or exclusions	\$200
Total	\$4,500

Managing type 2 diabetes (routine maintenance of A well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$1,220
- Patient pays \$4,180

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$4,000
Co-pays	\$0
Co-insurance	\$100
Limits or exclusions	\$80
Total	\$4,180

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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