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, www.myuhc.com. 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 1-877-797-8812 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $4,000 Individual / $8,000 Family Out of Network: $8,000 Individual / $16,000 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 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 services are 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/.
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: $8,150 Individual / $16,300 Family Out of Network: $16,300 Individual / $32,600 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-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 www.myuhc.com or call 1-877-797-8812 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.

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

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
		Your cost if you use a Network Provider	Your cost if you use an 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	$25 copay per visit, deductible does not apply	50% coinsurance	Under age 19 - Network visits are covered at No Charge. Virtual visits (Telehealth) - No Charge by a Designated Virtual Network Provider. No virtual coverage out-of-network.
	Specialist visit	$75 copay per visit, deductible does not apply	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge	50% coinsurance	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)	**Physician:** 20% coinsurance **Facility:** **Freestanding:** 20% coinsurance **Hospital:** 20% coinsurance	**Physician:** 50% coinsurance **Facility:** 50% coinsurance	Preauthorization required Non-Network for certain services or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	**Physician:** 20% coinsurance **Facility:** **Free Standing/ Office:** 20% coinsurance **Hospital:** 20% coinsurance	**Physician:** 50% coinsurance **Facility:** 50% coinsurance	Preauthorization required Non-Network for certain services or benefit reduces to 50% of allowed.
If you need drugs to treat your illness or condition More information about prescription drug coverage	Tier 1	Retail: $10 copay, deductible does not apply. Mail-Order: $25 copay, deductible does not apply.	Retail: $10 copay, deductible does not apply. Mail-Order: $25 copay, deductible does not apply.	Covers up to a 90-day supply for retail and mail order pharmacies. One retail copay applies per 30-day retail prescription. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/ or coinsurance may be applied. Certain drugs may have a prior authorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider (You will pay the most)	
is available at www.myuhc.com		Specialty Drugs: $10 copay, deductible does not apply.	Specialty Drugs: $10 copay, deductible does not apply.	requirement. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.
	Tier 2	Retail: $35 copay, deductible does not apply. Mail-Order: $87.50 copay, deductible does not apply. Specialty Drugs: $35 copay, deductible does not apply.	Retail: $35 copay, deductible does not apply. Mail-Order: $87.50 copay, deductible does not apply. Specialty Drugs: $35 copay, deductible does not apply.	
	Tier 3	Retail: $75 copay, deductible does not apply. Mail-Order: $187.50 copay, deductible does not apply. Specialty Drugs: $75 copay, deductible does not apply.	Retail: $75 copay, deductible does not apply. Mail-Order: $187.50 copay, deductible does not apply. Specialty Drugs: $75 copay, deductible does not apply.	
	Tier 4	Retail: $250 copay, deductible does not apply. Mail-Order: $625 copay, deductible does not apply. Specialty Drugs: $500 copay, deductible does not apply.	Retail: $250 copay, deductible does not apply. Mail-Order: $625 copay, deductible does not apply. Specialty Drugs: $500 copay, deductible does not apply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Freestanding/Office:** 20% coinsurance **Hospital:** 20% coinsurance	**Freestanding/Office:** 50% coinsurance **Hospital:** 50% coinsurance	Preauthorization required Non-Network for certain services or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	**Physician:** $75 copay per visit, deductible does not apply **Surgeon:**20% coinsurance	**Physician:** 50% coinsurance **Surgeon:** 50% coinsurance	
If you need immediate medical attention	Emergency room care	**ER Physician:**20% coinsurance **Facility:** $300 copay per visit then 20% coinsurance	**ER Physician:**20% coinsurance **Facility:** $300 copay per visit then 20% coinsurance*	*Out-of-network emergency services are covered at the Network benefit level.
	Emergency medical transportation	20% coinsurance	20% coinsurance*	
	Urgent care	**Urgent Care Physician:** $50 copay per visit, deductible does not apply **Facility:** $50 copay per visit, deductible does not apply	**Urgent Care Physician:** 50% coinsurance **Facility:** 50% coinsurance	One copay is applied between the physician charge and the facility charge for urgent care visits. Lab, x-rays or diagnostic testing are not included in the urgent care copay and are subject to the applicable benefit for these services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization required Non-Network for certain services or benefit reduces to 50% of allowed.
	Physician/surgeon fees	**Surgeon:**20% coinsurance	**Physician:** 50% coinsurance **Surgeon:** 50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Physician:** $75 copay per visit, deductible does not apply **Facility:** 20% coinsurance for other outpatient services	**Physician:** 50% coinsurance **Facility:** 50% coinsurance	None
	Inpatient services	**Physician:**20% coinsurance **Facility:** 20% coinsurance	**Physician:** 50% coinsurance **Facility:** 50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	**Primary Care Physician:** $25 copay per visit, deductible does not apply **Specialist Visit:** $75 copay per visit, deductible does not apply	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization required for out-of-network for certain services or benefit reduces to 50% of allowed.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 30 visits per year. Preauthorization required Out-of-Network for certain services or benefit reduces to 50% of allowed.
	Rehabilitation services	20% coinsurance	50% coinsurance	30 combined visits/year for rehabilitation and habilitation services. Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, and cognitive rehabilitation therapy.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per calendar year. Preauthorization required Non-Network for certain services or benefit reduces to 50% of allowed.
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior Authorization is required if greater than $1000. If you don't get Prior Authorization benefits could be reduced by 50% of the total cost of the service.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization required Non-Network for certain services or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not Covered	Not Covered	

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 (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Private-duty nursing
- Routine eye care (adult)
- 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.)

- Acupuncture
- Chiropractic care - 20 visits per calendar year
- Hearing Aids

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health InsuranceMarketplace. For more information about the Marketplace, visit www.HealthCare.govor call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your planfor a denial of a claim. This complaint is called a grievanceor appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plandocuments also provide complete information on how to submit a claim,appeal, or a grievancefor any reason to your plan. For more information about your rights, this notice, or assistance, contact: UnitedHealthCare at 1-877-797-8812, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 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 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 1-866-633-2446.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-866-633-2446.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 : $4,000
- Specialist $75
- 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

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible : $4,000
- Specialist $75
- 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

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100

Mia's Simple Fracture

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

- The plan's overall deductible : $4,000
- Specialist $75
- 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

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$100
Coinsurance	$0

Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,270

Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,130

What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,600

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

The company does 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, UT 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 member toll-free phone number listed on your ID card.

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, 1-800-537-7697 (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 member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費您您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

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 ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

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 sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises 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。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរសព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស អ្នក។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

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 ninaaltsoos nitł'izí bee nééhozinígíí bine'dę́ę́' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.