



 **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 1-866-633-2446 or visit welcometouhc.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 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$250 Individual / \$750 Family Per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and categories with a <u>copay</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . 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 <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Network: \$3,000 Individual / \$6,000 Family Per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See myuhc.com or call 1-866-633-2446 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Virtual visits (Telehealth)- \$10 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> , <u>deductible</u> does not apply. If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Specialist</u> visit	\$50 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$200 <u>copay</u> per service, <u>deductible</u> does not apply.	Not Covered	None

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

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 welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: \$10 <u>copay, deductible</u> does not apply. Mail-Order: \$25 <u>copay, deductible</u> does not apply.	Not Covered	<u>Provider</u> 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 You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. If you use an out-of- <u>network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 – Your Mid-Range Cost Option	Retail: \$35 <u>copay, deductible</u> does not apply. Mail-Order: \$87.50 <u>copay, deductible</u> does not apply.	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$70 <u>copay, deductible</u> does not apply. Mail-Order: \$175 <u>copay, deductible</u> does not apply.	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$350 <u>copay</u> per visit, <u>deductible</u> does not apply.	\$350 <u>copay</u> per visit, <u>deductible</u> does not apply.	None
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	*0% <u>coinsurance</u>	* <u>Network deductible</u> applies

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

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)	
	<u>Urgent care</u>	\$50 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	If you receive services in addition to <u>Urgent care</u> visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> per admission, <u>deductible</u> does not apply.	Not Covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	<u>Network</u> Partial hospitalization/intensive outpatient treatment: 0% <u>coinsurance</u> See your <u>policy</u> or <u>plan</u> document for additional information about EAP benefits.
	Inpatient services	\$500 <u>copay</u> per admission, <u>deductible</u> does not apply.	Not Covered	See your <u>policy</u> or <u>plan</u> document for additional information about EAP benefits.
If you are pregnant	Office visits	No Charge	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	\$500 <u>copay</u> per admission, <u>deductible</u> does not apply.	Not Covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	Not Covered	Limited to 60 visits per calendar year.
	<u>Rehabilitation services</u>	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Limits per calendar year: Physical, Speech, Occupational, Pulmonary: 20 visits each; Cardiac: 36 visits
	<u>Habilitative services</u>	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above. No limits apply for treatment of Autism Spectrum Disorder Services.

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

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)	
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	Not Covered	Limited to 60 days per calendar year (combined with inpatient rehabilitation).
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years.
	<u>Hospice services</u>	0% <u>coinsurance</u>	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

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.)

<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care • Glasses 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when travelling outside - the U.S. 	<ul style="list-style-type: none"> • Private duty nursing • Routine eye care • Routine foot care – Except as covered for Diabetes • Weight loss programs
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul style="list-style-type: none"> • Chiropractic (Manipulative care) – 20 visits per calendar year 	<ul style="list-style-type: none"> • Hearing aids - \$2,500 per calendar year
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* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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 Florida Department of Financial Services at 1-877-693-5236 or myfloridacfo.com.

Does this plan provide Minimum Essential Coverage? Yes

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:

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): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-633-2446.

————— *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)

■ <u>The plan's overall deductible</u>	\$250
■ <u>Specialist copay</u>	\$50
■ <u>Hospital (facility) copay</u>	\$500
■ <u>Other coinsurance</u>	0%

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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$810

Managing Joe's type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$250
■ <u>Specialist copay</u>	\$50
■ <u>Hospital (facility) copay</u>	\$500
■ <u>Other coinsurance</u>	0%

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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$30
The total Joe would pay is	\$1,430

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$250
■ <u>Specialist copay</u>	\$50
■ <u>Hospital (facility) copay</u>	\$500
■ <u>Other coinsurance</u>	0%

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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$850

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/portals/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 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.