



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 1-855-828-7715 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 <u>deductible</u> ?	\$0	See the Common Medical Events Chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	No.	See the Common Medical Events Chart below for your costs for services this <u>plan</u> covers.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>Network</u> : \$1,500 Individual / \$3,000 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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, 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 <u>network provider</u> ?	Yes. See www.myuhc.com or call 1-855-828-7715 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</u> charge 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 <u>referral</u> to see a <u>specialist</u> ?	Yes	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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 with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	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	Not Covered	<u>Primary Care Physician</u> must be assigned to member. Primary Care includes <u>network</u> OB/GYNs – no <u>referral</u> required. Under age 19 - Network visits are covered at No Charge. 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 visit</u>	\$35 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	Not Covered	We only accept electronic referrals from the assigned PCP. 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	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	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Tier 1 - Your Lowest Cost Option	Retail: \$10 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$20 <u>copay</u> , <u>deductible</u> does not apply.	Retail: \$10 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$20 <u>copay</u> , <u>deductible</u> does not apply.	Not Covered	Retail: Up to a 31 day supply. Mail-Order*: Up to a 90 day supply. Pharmacy out-of-pocket limit: \$1,500 Ind / \$10,200 Fam.
	Tier 2 - Your Mid-Range Cost Option	Retail: \$30 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$60 <u>copay</u> , <u>deductible</u> does not apply.	Retail: \$30 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$60 <u>copay</u> , <u>deductible</u> does not apply.	Not Covered	
	Tier 3 - Your Mid-Range Cost Option	Retail: \$60 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$120 <u>copay</u> , <u>deductible</u> does not apply.	Retail: \$60 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$120 <u>copay</u> , <u>deductible</u> does not apply.	Not Covered	
	Tier 4 - Your Highest Cost Option	Retail: \$90 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$180 <u>copay</u> , <u>deductible</u> does not apply.	Retail: \$90 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$180 <u>copay</u> , <u>deductible</u> does not apply.	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Not Covered	None
	Physician/ surgeon fees	No Charge	Not Covered	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> per visit, <u>deductible</u> does not apply	\$150 <u>copay</u> per visit, <u>deductible</u> does not apply	\$150 <u>copay</u> per visit, <u>deductible</u> does not apply	Emergency Copayment is waived if you are admitted
	<u>Emergency medical transportation</u>	No Charge	No Charge	No Charge	None
	<u>Urgent Care</u>	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
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	Not Covered	None
	Physician/ surgeon fees	No Charge	Not Covered	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	<u>Network</u> All Other: No Charge. See your policy 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	No Charge	Not Covered	See your policy or <u>plan</u> document for additional information about EAP benefits.
If you are pregnant	Office Visits	\$25 Primary Care Copayment \$35 Specialty Care Copayment	No Charge	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	No Charge	No Charge	Not Covered	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 facility services	\$500 <u>copay</u> per admission, <u>deductible</u> does not apply	\$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>	No Charge	No Charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Rehabilitation services</u>	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	Limits per calendar year: Cardiac, Pulmonary: 60 visits each; Physical/ Occupational/Speech: combined limit 60 visits.
	<u>Habilitative services</u>	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply	\$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 to children under age 19 or for treatment of Autism Spectrum Disorder Services for children under the age of 21.
	<u>Skilled nursing care</u>	\$500 <u>copay</u> per admission, <u>deductible</u> does not apply	\$500 <u>copay</u> per admission, <u>deductible</u> does not apply	Not Covered	None
	<u>Durable medical equipment</u>	No Charge	No Charge	Not Covered	None
	<u>Hospice services</u>	No Charge	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Covered	Covered	Covered	
	Children's glasses	Not Covered	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	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.)

- | | | |
|--------------------|---|--|
| • Acupuncture | • Long Term Care | • Routine Eye Care |
| • Cosmetic Surgery | • Non-emergency care when traveling outside - | • Routine foot care - Except as covered for Diabetes |
| • Dental Care | the US | • Weight loss programs |
| • Glasses | • Private duty nursing | |

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

- | | | |
|--|----------------|--|
| • Bariatric surgery - 1 procedure per lifetime | • Hearing aids | • Infertility Treatment - cycle limits may apply |
| • Chiropractic (manipulative) care | | |

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 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: 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 or Illinois Department of Insurance at 1-866-445-5364 or insurance.illinois.gov.

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 1-855-828-7715.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-828-7715.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-828-7715.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-828-7715.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-855-828-7715 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-828-7715.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-828-7715.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-855-828-7715.

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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copay</u>	\$35
■ Hospital (facility) <u>copay</u>	\$500
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Specialist office visits (*pre-natal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copay</u>	\$35
■ Hospital (facility) <u>copay</u>	\$500
■ Other <u>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*)

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copay</u>	\$35
■ Hospital (facility) <u>copay</u>	\$500
■ Other <u>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	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$560

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$900

Total Example Cost	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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.