This is only a summary. If you want more details about your coverage and costs, please call customer service at 800-632-3203 or visit www.myuhc.com.

Important Questions	Answers	Why this Matters:
What is the overall deductible per calendar year?	In-Network: $2,600 Individual / $5,200 Family Out-Of-Network: $5,200 Individual / $10,400 Family Does not apply to services listed below as "No Charge".	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. 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 **deductibles**.	
Is there an out–of–pocket limit on my expenses?	In-Network: $2,600 Individual / $5,200 Family Out-Of-Network: Unlimited Individual / Unlimited Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	**Premiums**, balanced-billed charges, deductibles, services this plan doesn't cover, penalties for failure to obtain pre-notification for services.	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?	This plan has no overall annual limit on the amount it will pay.	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes, this plan uses **network providers**. If you use an **out-of-network provider,** your costs may be more. For a list of **network providers**, visit www.myuhc.com or call 1-800-632-3203.	If you use a network doctor or **provider**, this plan will pay some or all of the costs of covered services. Plans use the term network, **preferred**, or participating for **providers** in their **network.**
Do I need a referral to see a specialist?	No	
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** payment of 20% would be $200. 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 an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care office visit	0% Coinsurance After Deductible	20% Coinsurance After Deductible	Virtual Visits - You pay the cost of the visit, which averages $40-$50 with a Designated Virtual Network Provider. No virtual visit coverage is available out-of-network.
	Specialist office visit	0% Coinsurance After Deductible	20% Coinsurance After Deductible	
	Other practitioner office visit	0% Coinsurance After Deductible	20% Coinsurance After Deductible	Cost share applies only for Chiropractic care. 30 visits per calendar year in-network and out-of-network combined. Prior authorization required for out-of-network.
	Preventive care screenings and immunizations	No charge to you if billed as preventive by your health care provider	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	0% Coinsurance After Deductible	20% Coinsurance After Deductible	Prior authorization required for out-of-network sleep studies.
	Imaging (CT/PET scans, MRIs)	0% Coinsurance After Deductible	20% Coinsurance After Deductible	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
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	Retail and Mail Order: 0% Coinsurance After Deductible	Not Covered	Plan pays 100% after deductible. Out-of-network not covered.
	Tier 2 - Your Midrange-Cost Option	Retail and Mail Order: 0% Coinsurance After Deductible	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail and Mail Order: 0% Coinsurance After Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Coinsurance After Deductible	20% Coinsurance After Deductible	
	Physician/surgeon fees	0% Coinsurance After Deductible	20% Coinsurance After Deductible	
If you need immediate medical attention	Emergency room services	0% Coinsurance After Deductible	0% Coinsurance After Deductible	Non-Emergency not covered. In-network applies to all providers for emergency room services.
	Emergency medical transportation	0% Coinsurance After Deductible	0% Coinsurance After Deductible	In-network applies to all providers for emergency medical transportation.
	Urgent care	0% Coinsurance After Deductible	20% Coinsurance After Deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Coinsurance After Deductible	20% Coinsurance After Deductible	
	Physician/surgeon fee	0% Coinsurance After Deductible	20% Coinsurance After Deductible	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% Coinsurance After Deductible	20% Coinsurance After Deductible	The Employee Assistance Program offers up to 6 visits at no cost. Out-of-network requires prior authorization.
	Mental/Behavioral health inpatient services	0% Coinsurance After Deductible	20% Coinsurance After Deductible	
	Substance use disorder outpatient services	0% Coinsurance After Deductible	20% Coinsurance After Deductible	
	Substance use disorder inpatient services	0% Coinsurance After Deductible	20% Coinsurance After Deductible	
If you are pregnant	Prenatal and postnatal care	0% Coinsurance After Deductible	20% Coinsurance After Deductible	Your cost includes physician delivery charges. Routine prenatal care covered at no cost. **Newborns must be added to the plan within 30 days of birth.**
	Delivery and all inpatient services	0% Coinsurance After Deductible	20% Coinsurance After Deductible	Prior authorization needed if stay is longer than 48 hours (72 hours for c-section).

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% Coinsurance After Deductible	20% Coinsurance After Deductible	240 visits per calendar year. In-network and out-of-network visits combined.
	Rehabilitation services	0% Coinsurance After Deductible	20% Coinsurance After Deductible	Pulmonary, Occupational, Physical & Speech have 30 visits each, per calendar year, in-network and out-of-network combined. Cardiac has 20 visits per calendar year, in-network and out-of-network combined. Additional visits may be requested.
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	0% Coinsurance After Deductible	20% Coinsurance After Deductible	Maximum of 365 days per lifetime. In-network and out-of-network combined. Prior authorization required for out-of-network.
	Durable medical equipment	0% Coinsurance After Deductible	20% Coinsurance After Deductible	Prior authorization required for out-of-network or if cost is greater than $1000.
	Hospice service	0% Coinsurance After Deductible	20% Coinsurance After Deductible	Prior authorization required for out-of-network.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other excluded services. Limitations may apply.)

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision hardware
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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. Limitations may apply.)

- Chiropractic care
- Hearing aids
- Private-duty nursing

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 1-877-722-2667. 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 us at 1-800-632-3203 or visit www.myuhc.com.
Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at http://www.dol.gov/ebsa/healthreformand 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:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-800-632-3203.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-632-3203.
- Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-632-3203.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-632-3203.

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

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 also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,370
- **Patient pays:** $170

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	$20
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	$170

Note: This example assumes the patient has already paid $2,580 of their in-network deductible for the year, prior to the delivery.

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,720
- **Patient pays:** $2,680

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	$2,600
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	$2,680

Note: This example assumes the patient has paid none of their in-network deductible for the year, prior to receiving these services.

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs) that help you pay out-of-pocket expenses.