



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 1-800-964-8826.


| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible? | Network/Non-Network: \$1,500 Individual / \$3,000 Family Does not apply to prescription drugs, and services listed below as "No Charge". Per calendar year. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, 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 deductibles. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an out-of-pocket limit on my expenses? | Network/Non-Network: \$2,000 per covered person | 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? | Premium, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-notification for services deductibles, prescription drugs and copays. | 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 specific covered services, such as office visits. |
| Does this plan use a network of providers? | Yes, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see www.myuhc.com or call 1-800-382-4264 for a list of network providers. See www.caremark.com for a list of pharmacy providers. | 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 network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred, or participating for providers in their network. See the 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 can see the 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. |

Questions: Call 1-800-964-8826 or visit www.myuhc.com. If you aren't clear about any of the terms used in this form, see the Glossary.

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You can view the Glossary at www.dol.gov/ebsa/healthreform or call the phone number above to request a copy. **This is only a summary.**

It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

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- Co-payments (copays) are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
 - Co-insurance (co-ins) 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 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 a non-network provider charges more than the allowed amount, you may have to pay the difference. For example, if a non-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.)
 - Your costs for network providers will be lower than non-network providers.

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|--|--|---|---|---|
| | | Network Provider | Non-Network Provider | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 20% co-ins | 20% co-ins | None |
| | Specialist visit | 20% co-ins | 20% co-ins | None |
| | Other practitioner office visit | 20% co-ins for Manipulative (Chiropractic) Services | 20% co-ins for Manipulative (Chiropractic) Services | Limited to 35 visits of Manipulative (Chiropractic) services per calendar year. |
| | Preventive care / screening / immunization | No Charge | No Charge | Includes preventive health services specified in the health care reform law. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% co-ins | 20% co-ins | Preventive diagnostic services provided at No Charge. |
| | Imaging (CT / PET scans, MRIs) | 20% co-ins | 20% co-ins | None |
| If you need drugs to treat your illness or condition | Tier 1 – Your Lowest-Cost Option (Generic) | 20% co-ins, after deductible | 20% co-ins, after deductible | 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 Certain drugs may have a pre-notification requirement or may result in a higher cost. |
| | Tier 2 – Your Midrange-Cost Option (Preferred Brand) | 20% co-ins, after deductible | 20% co-ins, after deductible | |
| More information about prescription drug coverage is available at www.caremark.com | | | | |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|--|---|------------------------------|--|
| | | Network Provider | Non-Network Provider | |
| | Tier 3 – Your Highest-Cost Option (Non-Preferred & Others) | 20% co-ins, after deductible | 20% co-ins, after deductible | <p>If you use a non-network Pharmacy, you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.</p> <p>Tier 1 Contraceptives covered at No Charge.</p> <p>See the website listed for information on drugs covered by your plan. Not all drugs are covered.</p> |
| | Tier 4 – Additional High-Cost Options (Specialty) | Specialty Drugs covered at Tier 2 or Tier 3 copay as applicable (Mail Order only) | Not Applicable | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% co-ins | 20% co-ins | None |
| | Physician / surgeon fees | 20% co-ins | 20% co-ins | None |
| If you need immediate medical attention | Emergency room services | 20% co-ins | 20% co-ins | Notification is required if results in an Inpatient Stay. |
| | Emergency medical transportation | 20% co-ins | 20% co-ins | None |
| | Urgent care | 20% co-ins | 20% co-ins | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% co-ins | 20% co-ins | Prior Notification is required. |
| | Physician / surgeon fees | 20% co-ins | 20% co-ins | None |
| If you have mental health, behavioral health, or substance abuse needs | Mental / Behavioral health outpatient services | 20% co-ins | 20% co-ins | None |
| | Mental / Behavioral health inpatient services | 20% co-ins | 20% co-ins | None |
| | Substance use disorder outpatient services | 20% co-ins | 20% co-ins | None |
| | Substance use disorder inpatient services | 20% co-ins | 20% co-ins | None |
| If you become pregnant | Prenatal and postnatal care | 20% co-ins | 20% co-ins | Additional copays, deductibles, or co-ins may apply. Routine pre-natal care is covered at No Charge. |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|--|-------------------------------------|-----------------------------|-----------------------------|---|
| | | Network Provider | Non-Network Provider | |
| | Delivery and all inpatient services | 20% co-ins | 20% co-ins | Additional copays, deductibles, co-ins and inpatient Notification may apply. |
| If you have a recovery or other special health needs | Home health care | 0% co-ins, after deductible | 0% co-ins, after deductible | Limited to 40 visits per calendar year. Pre-notification required non-network. |
| | Rehabilitation services | 20% co-ins | 20% co-ins | Network Benefits are unlimited: physical therapy; occupational therapy; speech therapy; pulmonary rehabilitation and cardiac rehabilitation. 30 visits of post cochlear implant aural therapy |
| | Habilitation services | Not Covered | Not Covered | No coverage for Habilitation services. |
| | Skilled nursing care | 0% co-ins, after deductible | 0% co-ins, after deductible | Limited to 60 days per calendar year, (limit is combined with IP Rehabilitation Services). Pre-notification required non-network. |
| | Durable medical equipment | 20% co-ins | 20% co-ins | Pre-notification required for DME over \$1,000 or no coverage. |
| | Hospice service | 20% co-ins | 20% co-ins | Inpatient pre-notification required. |
| If your child needs dental or eye care | Eye exam | Not Covered | Not Covered | No coverage for Eye exams. |
| | 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 excluded services.) | | |
|--|--|---|
| <ul style="list-style-type: none"> • Cosmetic Surgery • Dental Care (Adult/Child) | <ul style="list-style-type: none"> • Glasses • Habilitation Services • Long-term care | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Routine eye care • 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"> • Hearing aids may be covered with limitations • Acupuncture • Bariatric Surgery, if member covered on plan for at least 2 years | <ul style="list-style-type: none"> • Infertility Treatment – may be covered with limitations | <ul style="list-style-type: none"> • Private-duty nursing (outpatient basis) |

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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit <http://www.dol.gov/ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit <http://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 your human resource department 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/prgrams/consumer/capgrants/index.html>.

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 biniiye nanitinigii number bikaa'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.-----

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) | Managing type 2 diabetes (routine maintenance of a well-controlled condition) |
|---|---|
| <input type="checkbox"/> Amount owed to providers: \$7,540 <input type="checkbox"/> Plan Pays \$ 5,340 <input type="checkbox"/> Patient Pays \$ 2,200 | <input type="checkbox"/> Amount owed to providers: \$5,400 <input type="checkbox"/> Plan Pays \$ 3,320 <input type="checkbox"/> Patient Pays \$ 2,080 |
| Sample care costs: | Sample care costs: |
| Hospital charges (mother) \$2,700 | Prescriptions \$2,900 |
| Routine obstetric care \$2,100 | Medical Equipment and Supplies \$1,300 |
| Hospital charges (baby) \$900 | Office Visits and Procedures \$700 |
| Anesthesia \$900 | Education \$300 |
| Laboratory tests \$500 | Laboratory tests \$100 |
| Prescriptions \$200 | Vaccines, other preventive \$100 |
| Radiology \$200 | Total \$5,400 |
| Vaccines, other preventive \$40 | |
| Total \$7,540 | |
| Patient pays: | Patient pays: |
| Deductibles \$1,500 | Deductibles \$1,500 |
| Co-pays \$0 | Co-pays \$200 |
| Co-insurance \$500 | Co-insurance \$300 |
| Limits or exclusions \$200 | Limits or exclusions \$80 |
| Total \$2,200 | Total \$2,080 |

Questions and answers about Coverage Examples:

| | | |
|---|--|---|
| <p>What are some of the assumptions behind the Coverage Examples?</p> <ul style="list-style-type: none"> • Costs don't include premiums. • Sample care costs are based on national averages supplied to 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. • If other than individual coverage, the Patient Pays amount may be more. | <p>What does a Coverage Example show?</p> <p>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.</p> | <p>Can I use Coverage Examples to compare plans?</p> <p>✓ <u>Yes</u>. 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</p> |
| | <p>Does the Coverage Example predict my own care needs?</p> <p>✗ <u>No</u>. 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.</p> | <p>Are there other costs I should consider when comparing plans?</p> <p>✓ <u>Yes</u>. 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.</p> |
| | <p>Does the Coverage Example predict my future expenses?</p> <p>✗ <u>No</u>. 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.</p> | |

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