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: $400 Individual / $800 Family Non-Network: $1,200 Individual / $2,400 Family Does not apply to copays, 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.	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: $1,200 Individual / $2,400 Family Non-Network: $3,600 Individual / $7,200 Family	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 don't need a referral to see a specialist.	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.

- 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.)
- This plan may encourage you to use network providers by charging you lower deductibles, co-payments and co-insurance amounts.

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	$15 copay per visit	30% co-ins	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$30 copay per visit	30% co-ins	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$30 copay per visit of Spinal Manipulative services	30% co-ins of Spinal Manipulative services	Limited to 1 visit of Spinal Manipulative services per day. Covered up to 35 consecutive days per condition. Treatment will be reviewed for medical necessity at 35 days.
	Preventive care / screening / immunization	No Charge	10% co-ins	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% co-ins	None
	Imaging (CT / PET scans, MRIs)	10% co-ins	30% co-ins	None
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest-Cost Option (Generic)	Retail: $5 copay; Mail order: $10 copay	Retail: $5 copay	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,

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
More information about prescription drug coverage is available at www.caremark.com	Tier 2 – Your Midrange-Cost Option (Preferred Brand)	Retail: $30 copay; Mail order: $60 copay	Retail: $30 copay	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. 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. Tier 1 Contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 3 – Your Highest-Cost Option (Non-Preferred & Others)	Retail: $60 copay; Mail order: $120 copay	Retail: $60 copay	
	Tier 4 – Additional High-Cost Option (Specialty)	Specialty Drugs covered at Tier 2 or Tier 3 copays as applicable (Mail Order only)	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins	30% co-ins	None
	Physician / surgeon fees	10% co-ins	30% co-ins	None
If you need immediate medical attention	Emergency room services	$200 copay per visit, then 10% co-ins	$200 copay per visit, then 10% co-ins	Copay is waived if admitted.
	Emergency medical transportation	10% co-ins	10% co-ins	None
	Urgent care	$40 copay per visit	10% co-ins	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay per inpatient stay, then 10% co-ins	$300 copay per inpatient stay, then 40% co-ins	Pre-notification required non-network.
	Physician / surgeon fees	10% co-ins	30% co-ins	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	$15 copay per visit	40% co-insurance	Must receive prior authorization through the Mental Health/Substance Abuse Designee.
	Mental / Behavioral health inpatient services	$300 copay per inpatient stay, then 10% co-ins	$300 copay per inpatient stay, then 40% co-ins	Must receive prior authorization through the Mental Health/Substance Abuse Designee.
	Substance use disorder outpatient services	$15 copay per visit	40%co-ins	Must receive prior authorization through the Mental Health/Substance Abuse Designee.
	Substance use disorder inpatient services	$300 copay per inpatient stay, then 10% co-ins	$300 copay per inpatient stay, then 40% co-ins	Must receive prior authorization through the Mental Health/Substance Abuse Designee.
If you become pregnant	Prenatal and postnatal care	$15 Global Maternity copay	30% co-ins	Additional copays, deductibles, or co-ins may apply. Routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	$300 copay per inpatient stay, then 10% co-ins	$300 copay per inpatient stay, then 40% 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 for skilled care service per calendar year. Pre-notification required non-network.
	Rehabilitation services	$30 copay per outpatient visit	30% co-ins	In and Out of Network benefits are unlimited.
	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	10% co-ins	30% co-ins	Prior-notification required for DME over $1,000 or no coverage.
	Hospice service	0% co-ins, after deductible	0% co-ins, after deductible	Inpatient pre-notification required for non-network.
If your child needs dental	Eye exam	Not Covered	Not Covered	No coverage for Eye exam.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
or eye care	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.)		
• Cosmetic Surgery • Dental Care (Adult/Child)	• Glasses • Habilitation Services • Long-term care	• 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.)		
• Hearing aids - may be covered with limitations • Acupuncture • Bariatric Surgery, if member covered on plan for at least 2 years	• Infertility Treatment – may be covered with limitations	• 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:///ciio.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)

- ☐ Amount owed to providers: $7,540
- ☐ Plan Pays $ 6,240
- ☐ Patient Pays $ 1,300

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	$400
Co-pays	$300
Co-insurance	$400
Limits or exclusions	$200
Total	$1,300

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

- ☐ Amount owed to providers: $5,400
- ☐ Plan Pays $ 4,320
- ☐ Patient Pays $ 1,080

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	$400
Co-pays	$500
Co-insurance	$100
Limits or exclusions	$80
Total	$1,080

Questions and answers about 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 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.

What does a Coverage Example show?

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.

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 **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.

Questions: Call 1-800-964-8824 or visit www.myuhc.com. If you aren't clear about any of the terms used in this form, see the Glossary.
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.