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 1-866-844-4864.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.cciio.cms.gov or call 1-866-844-4864 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$2,000** Individual / **$4,000** Family Non-Network: **$ 4,000** Individual / **$ 8,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$6,500** Individual / **$13,000** Family Non-Network: **$ 13,000** Individual / **$ 26,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call **1-866-844-4864** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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)	Non-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	$35 copay per visit, deductible does not apply.	40% coinsurance	Virtual visits (Telehealth) - $25 copay per visit by a Designated Virtual Network Provider, deductible does not apply. No virtual coverage non-network If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	$35 copay per visit, deductible does not apply.	40% coinsurance	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance deductible does not apply.	40% coinsurance	Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 – Generic drugs	Retail: $15 copay, deductible does not apply. Mail-Order: $30 copay, deductible does not apply.	Not Covered	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 requirement or may result in a higher cost. If you use a non-network pharmacy preauthorization (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 2 – Preferred Brand drugs	Retail: $30 copay, deductible does not apply. Mail-Order: $60 copay, deductible does not apply.	Not Covered	
	Tier 3 – Non-Preferred Brand drugs	Retail: $50 copay, deductible	Not Covered	

* 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)	Non-Network Provider (You will pay the most)	
		does not apply. Mail-Order: $100 copay, deductible does not apply.		You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Certain preventive medications are covered at No Charge.
	Tier 4 – Specialty drugs	Retail: 10% coinsurance with a $150 copay maximum, deductible does not apply. Mail-Order: Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Ambulatory Surgical Center/Office:** 15% coinsurance **Hospital:** 20% coinsurance	40% coinsurance	Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	**Ambulatory Surgical Center/Office:**15% coinsurance **Hospital:** 20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay per visit, then 20% coinsurance, deductible does not apply.	$250 copay per visit, then 20% coinsurance, deductible does not apply.	None
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network deductible applies
	Urgent care	$50 copay per visit, deductible does not apply.	40% coinsurance	If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	**Ambulatory Surgical Center/Office:** 5%	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
		coinsurance **Hospital:** 20% coinsurance		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay per visit, deductible does not apply.	40% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance. Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
If you are pregnant	Office visits	No Charge	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	**Ambulatory Surgical Center/Office:** 15% coinsurance **Hospital:** 20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Inpatient preauthorization may apply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	20% coinsurance	40% coinsurance	Limits per calendar year: Physical, Speech, Occupational , Pulmonary: 20 visits each; Cardiac: 36 visits Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount.
	Habilitative services	20% coinsurance	40% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount.
	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled Nursing is limited to 60 days per calendar year. Inpatient rehabilitation limited to 30 days. Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required non-network for DME over $1,000

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				or benefit reduces to 50% of allowed amount
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required non-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
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.)

- Bariatric surgery
- Children's glasses
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine eye care
- Routine foot care – Except as covered for Diabetes
- Weight loss programs

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

- Acupuncture– 15 visits per calendar year
- Chiropractic (Manipulative care) – 15 visits per calendar year
- Hearing aids