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 1-888-332-8885.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 deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No	You don't have to meet deductibles for specific services.
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: **$1,500** Individual Non-Network: **$3,000** Individual Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services.
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 prenotification 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 **1-888-332-8885** 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	$25 copay per visit	$50 copay per visit	Virtual visits (Telehealth) - $25 copay per visit by a Designated Virtual Network Provider. No virtual coverage non-network. If you receive services in addition to office visit, additional copays or coinsurance may apply e.g. surgery.
	Specialist visit	$25 copay per visit	$50 copay per visit	If you receive services in addition to office visit, additional copays or coinsurance may apply e.g. surgery.
	Preventive care/screening/ Immunization	No Charge	$50 copay per visit, then 20% 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)	No Charge	20% coinsurance	Prenotification is required non-network for certain services or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	Prenotification 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 – Your Lowest Cost Option	Retail: $10 copay Mail-Order: $20 copay	Retail: $10 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, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 2 – Your Mid-Range Cost Option	Retail: $25 copay Mail-Order: $50 copay	Retail: $25 copay	

* 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)	
	Tier 3 – Your Mid-Range Cost Option	Retail: $35 copay Mail-Order: $70 copay	Retail: $35 copay	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.
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance,	Prenotification is required non-network for certain services or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay per visit	$100 copay per visit	None
	Emergency medical transportation	$50 copay per transport	$50 copay per transport	None
	Urgent care	$50 copay per visit	$50 copay per visit	If you receive services in addition to Urgent care visit, additional copays, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Prenotification is required non-network or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	No coverage for mental health, behavioral health, and substance abuse through UHC. Contact Mercy Managed Behavioral Health Program, (800) 413-8008, Option 2, same co-pay as office visit.
	Inpatient services	Not Covered	Not Covered	

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 need help recovering or have other special health needs	Home health care	$25 copay per visit	$50 copay per visit	Limited to 60 visits per calendar year. Prenotification is required non-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	$25 copay per visit	$50 copay per visit	Limits per calendar year: Physical, Speech, Occupational: 20 visits each; Cardiac: 36 visits; Pulmonary: 36 visits. Prenotification required non-network for certain services or benefit reduces to 50% of allowed amount.
	Habilitative services	$25 copay per visit	$50 copay per visit	Services are provided under and limits are combined with Rehabilitation Services above. Prenotification required non-network for certain services or benefit reduces to 50% of allowed amount.
	Skilled nursing care	10% coinsurance	20% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Prenotification is required non-network or benefit reduces to 50% of allowed amount.
	Durable medical equipment	10% coinsurance	20% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. Prenotification is required non-network for DME over $1,000 or no coverage.
	Hospice services	No Charge	Not Covered	Limited to 180 days per lifetime. Prenotification is required non-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.

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
- Cosmetic surgery
- Dental care (refer to your Delta Dental coverage)
- Long-term care
- Mental Health, Behavioral Health, or Substance Abuse (contact Mercy Managed Behavioral Health)
- Non-emergency care when traveling outside -the U.S.
- Private duty nursing
- 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.)

- Bariatric surgery
- Chiropractic (Manipulative care) – 26 visits per calendar year
- Glasses - (refer to PMBS allowance)
- Hearing aids - (refer to PMBS allowance)
- Routine eye care

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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 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.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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