**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, visit www.welcometouhc.com/uhcwest or by calling 1-800-624-8822. 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 1-800-624-8822 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $500/individual or $1,000/family. | 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, primary care services, specialist visits, testing and tier 1 drugs are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the 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 preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. Prescription drugs – $100 individual / $200 family – applies to Tiers 2 through 4 drugs. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | For participating providers $8,000 individual / $16,000 family. | 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?** | Copayments for certain services, premiums, balance-billing charges, optional addenda, and health care this plan doesn't cover. | 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 www.welcometouhc.com/uhcwest or call 1-800-624-8822 for a list of participating 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 a non-participating 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 participating provider might use a non-participating 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?** | Yes, written or oral approval is required, based upon medical policies. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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 |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating 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 / office visit and No charge / Virtual visits by a designated virtual participating provider; deductible does not apply | Not covered | If you receive services in addition to office visit, additional copayments, deductibles or coinsurance may apply. |
| | Specialist visit | $70 copay / visit; deductible does not apply | Not covered | Member is required to obtain a referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services, reproductive health care services within the Participating Medical Group and Emergency / Urgently needed services. If you receive services in addition to office visit, additional copayments, deductibles or coinsurance may apply. |
| | Preventive care/screening/ immunization | No charge; deductible does not apply | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab $40 copay / test Radiology (Standard) $40 copay / test; deductible does not apply | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | $300 copay / test; deductible does not apply | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.welcometouhc.com/uhcwest. | Tier 1 | $15 copay / prescription retail<br>$30 copay / prescription mail order<br>$15 copay / specialty drugs; deductible does not apply | Not covered | Participating 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. When applicable: Mail-Order Specialty drugs - Up to a 31 day supply. All limits are unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Copayment Maximum of $250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. |
| | Tier 2 | $50 copay / prescription retail<br>$100 copay / prescription mail order<br>$150 copay / specialty drugs | Not covered | |
| | Tier 3 | $100 copay / prescription retail<br>$200 copay / prescription mail order<br>$250 copay / specialty drugs | Not covered | |
| | Tier 4 | 25% coinsurance / prescription retail up to a $250 copay max per prescription<br>25% coinsurance / prescription mail order up to a $500 copay max per prescription<br>25% coinsurance / specialty drugs up to a $250 copay max per prescription | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not covered | None |
| | Physician/surgeon fees | 20% coinsurance; deductible does not apply | Not covered | |
| **If you need immediate medical attention** | Emergency room care | $500 copay / visit | $500 copay / visit | Copayment waived if admitted. |
| | Emergency medical transportation | $100 copay / trip; deductible does not apply | $100 copay / trip; deductible does not apply | None |
| | Urgent care | $35 copay / visit; deductible does not apply | $100 copay / visit; deductible does not apply | If you receive services in addition to urgent care, additional copayments, deductibles or coinsurance may apply. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not covered | None |
| | Physician/surgeon fees | 20% coinsurance; deductible does not apply | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $35 copay / office visit and No charge for all other outpatient services; deductible does not apply | Not covered | None |
| | Inpatient services | 20% coinsurance | Not covered | |
| **If you are pregnant** | Office visits | No charge; deductible does not apply | Not covered | Cost sharing does not apply to certain preventive services. Routine pre-natal care and first postnatal visit is covered at No charge. Depending on the type of services, additional copayments, deductibles or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | No charge; deductible does not apply | Not covered | |
| | Childbirth/delivery facility services | 20% coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | $35 copay / visit; deductible does not apply | Not covered | Limited to 100 visits per year. Limit does not apply to home health visits for rehabilitation and habilitation purposes. |
| | Rehabilitation services | $35 copay / visit; deductible does not apply | Not covered | None |
| | Habilitative services | $35 copay / visit; deductible does not apply | Not covered | |
| | Skilled nursing care | 20% coinsurance | Not covered | Up to 100 days per benefit period. |
| | Durable medical equipment | $70 copay / item; deductible does not apply | Not covered | None |
| | Hospice services | No charge; deductible does not apply | Not covered | If inpatient admission, subject to inpatient copayments, deductibles or coinsurance. |
| **If your child needs dental or eye care** | Children's eye exam | No charge; deductible does not apply | Not covered | 1 exam per year. |
| | Children's glasses | 20% coinsurance; deductible does not apply | Not covered | One pair every 12 months. |
| | Children's dental check-up | No charge; deductible does not apply | Not covered | Cleanings covered 2 times per 12 months. Additional limitations may apply. |

**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.) | | |
|---|---|---|
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Infertility treatment | • Private-duty nursing | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture | • Chiropractic care | • Routine eye care (Adult) |
| • Bariatric surgery | • Hearing aids | |

**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 are: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov., or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. 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 on how 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: your human resource department, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform

Additionally, a consumer assistance program may help you file your appeal. Contact Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov

**Does this plan provide Minimum Essential Coverage? Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**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.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-8822.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-8822.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-800-624-8822.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-8822.

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

**About these Coverage Examples:**

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

## Peg is Having a Baby
(9 months of participating provider pre-natal care and a hospital delivery)

| | |
|---|---|
| ■ The plan's overall deductible | $500 |
| ■ Specialist copayment | $70 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $500 |
| Copayments | $100 |
| Coinsurance | $1,600 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,260** |

## Managing Joe's Type 2 Diabetes
(a year of routine participating provider care of a well-controlled condition)

| | |
|---|---|
| ■ The plan's overall deductible | $500 |
| ■ Specialist copayment | $70 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Primary care physician office visit *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $100 |
| Copayments | $1,500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,600** |

## Mia's Simple Fracture
(participating provider emergency room visit and follow up care)

| | |
|---|---|
| ■ The plan's overall deductible | $500 |
| ■ Specialist copayment | $70 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copayments | $800 |
| Coinsurance | $40 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$840** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-624-8822. *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

**Subject to Regulatory Approval**