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 uhc.com/shopma or by calling 1-877-856-2430. 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?	Network: $1,000 Individual / $2,000 Family out-of-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 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 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: $5,000 Individual / $10,000 Family out-of-Network: $15,000 Individual / $30,000 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?	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 uhc.com/shopmadocfindchoiceplus or call 1-877-856-2430 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)	Out-of-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, deductible does not apply	20% coinsurance	Virtual visits (Telehealth) - $10 copay per visit by a Designated Virtual Network Provider, deductible does not apply. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Specialist visit	$45 copay per visit, deductible does not apply	20% 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	* 20% coinsurance	Includes preventive health services specified in the health care reform law. 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. *Deductible/coinsurance may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay per service	20% coinsurance	Preauthorization required for out-of-Network for certain services or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	$200 copay per service	20% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network 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 uhc.com/rxfind	Tier 1 - Your Lowest-Cost Option	Deductible does not apply. Retail: $20 copay Mail-Order: $40 copay	Deductible does not apply. Retail: $20 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order*: Up to a 90 day supply or *Preferred 90 Day Retail Network pharmacy. If you use an out-of-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Copay is per prescription order up to the day supply limit listed above. 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. 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. Not all drugs are covered. If a dispensed drug has a chemically equivalent drug, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Deductible does not apply. Retail: $40 copay Mail-Order: $80 copay	Deductible does not apply. Retail: $40 copay	
	Tier 3 - Your Midrange-Cost Option	Deductible does not apply. Retail: $60 copay Mail-Order: $180 copay	Deductible does not apply. Retail: $60 copay	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay per visit	20% coinsurance	Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay per visit	$150 copay per visit	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	$45 copay per visit, deductible does not apply	20% 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)	$500 copay per admission	20% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit, deductible does not apply	20% coinsurance	Network partial hospitalization /intensive outpatient treatment: 0% coinsurance Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.
	Inpatient services	$500 copay per admission	20% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	$500 copay per admission	20% coinsurance	Additional copays, deductibles, coinsurance may apply. Inpatient preauthorization apply for out-of-Network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Rehabilitation services	$45 copay per outpatient visit, deductible does not apply	20% coinsurance	Limits per calendar year: Physical & Occupational 44 visits each. Pulmonary: 20 visits; Speech & Cardiac: Unlimited.
	Habilitation services	$45 copay per outpatient visit, deductible does not apply	20% coinsurance	Limits per calendar year: Physical & Occupational 44 visits each. Speech: Unlimited. Cost share applies for outpatient services only. Preauthorization required for out-of-Network inpatient services or benefit to 50% of allowed.
	Skilled nursing care	$500 copay per admission	20% coinsurance	Skilled nursing is limited to 100 days per calendar year. (Inpatient Rehabilitation and Habilitation limited to 60 days each). Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization required for out-of-Network Durable medical equipment over $1,000 or no coverage.
	Hospice services	0% coinsurance	20% coinsurance	Preauthorization required for out-of-Network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam	$25 copay per visit, deductible does not apply	20% coinsurance	One exam every 12 months.
	Children's glasses	50% coinsurance, deductible does not apply	50% coinsurance	One pair every 12 months.
	Children's dental check-up	0% coinsurance	20% coinsurance	Cleanings covered 2 times per 12 months.

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 (Adult)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Foot Care

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

- Bariatric Surgery
- Chiropractic care
- Hearing Aids - $2,000 every 36 months
- Infertility Treatment
- Routine eye care (Adult)-1 exam/12 months
- Weight Loss Programs

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: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration. You may also contact us at 1-877-856-2430 . 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: 1-877-856-2430 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Massachusetts Division of Insurance at 617-521-7794 or www.mass.gov/ocabr/government/oca-agencies/doi-lp.

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 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 1-877-856-2430 .
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-856-2430 .
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-856-2430 .
Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-877-856-2430 .

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 in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $ 1,000
- **Specialist copayment** $45
- **Hospital (facility) copayment** $500
- **Other coinsurance** 20%

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

Total Example Cost	$12,800
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,860

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $ 1,000
- **Specialist copayment** $45
- **Hospital (facility) copayment** $500
- **Other coinsurance** 20%

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

Total Example Cost	$7,400
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$1,930

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $ 1,000
- **Specialist copayment** $45
- **Hospital (facility) copayment** $500
- **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	$1,900
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,500

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

Notice of Non-Discrimination

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.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមមួរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά (Greek), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

ધ્યાન આપો: જો તમ ે ગુજ રાતી (Gujarati) બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મલ્ ૂ ય ે પ્રાપ્ય છે. કૃપા કરી તમારા આઇડન્ ે ટીફિકેશન કાડડ પર આપેલા ટોલ-ફ્રી નબં ર પર કોલ કરો.