



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?	<u>Network</u> : \$3,500 Individual / \$7,000 Family Per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	<u>Network</u> : \$6,850 Individual / \$13,700 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See uhc.com/shopmadocfindnavigate or call 1-877-856-2430 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider Network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's Network</u> . You will pay the most if you use an <u>out-of-Network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>Network provider</u> might use an <u>out-of-Network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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 with referral (You will pay the least)	Network Provider without referral	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	\$45 <u>copay</u> per visit	Not Covered	Not Covered	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery. Virtual visits (Telehealth) - \$10 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> . Primary Physician must be assigned. <u>Network OB/GYNs</u> - no <u>referral</u> required.
	<u>Specialist</u> visit	\$75 <u>copay</u> per visit	Not Covered	Not Covered	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery. We only accept electronic <u>referrals</u> from the assigned <u>Primary Care Physician</u> .
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$60 <u>copay</u> per service	\$60 <u>copay</u> per service	Not Covered	X-ray - \$75 <u>copay</u> per visit .
	Imaging (CT/PET scans, MRIs)	\$500 <u>copay</u> per service	\$500 <u>copay</u> per service	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral	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	Retail: \$35 <u>copay</u> Mail-Order: \$70 <u>copay</u>	Retail: \$35 <u>copay</u> Mail-Order: \$70 <u>copay</u>	Not Covered	<p><u>Provider</u> 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-<u>Network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u>. <u>Copay</u> is per prescription order up to the day supply limit listed above.</p> <p>You may need to obtain certain drugs, including certain <u>specialty drugs</u>, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. See the website listed for information on drugs covered by your <u>plan</u>. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.</p> <p>If a dispensed drug has a chemically equivalent drug, the cost difference between drugs in addition to any applicable <u>copay</u> and/or <u>coinsurance</u> may be applied.</p>
	Tier 2 - Your Midrange-Cost Option	Retail: \$75 <u>copay</u> Mail-Order: \$150 <u>copay</u>	Retail: \$75 <u>copay</u> Mail-Order: \$150 <u>copay</u>	Not Covered	
	Tier 3 - Your Midrange-Cost Option	Retail: \$150 <u>copay</u> Mail-Order: \$450 <u>copay</u>	Retail: \$150 <u>copay</u> Mail-Order: \$450 <u>copay</u>	Not Covered	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 <u>copay</u> per visit	Not Covered	Not Covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not Covered	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$300 <u>copay</u> per visit	\$300 <u>copay</u> per visit	\$300 <u>copay</u> per visit	None
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with a referral (You will pay the least)	Network Provider without referral	Out-of-Network Provider (You will pay the most)	
	<u>Urgent care</u>	\$75 <u>copay</u> per visit	\$75 <u>copay</u> per visit	Not Covered	If you receive services in addition to <u>urgent care</u> visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 <u>copay</u> per admission	Not Covered	Not Covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not Covered	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$45 <u>copay</u> per visit	\$45 <u>copay</u> per visit	Not Covered	<u>Network partial hospitalization</u> /intensive outpatient treatment: 0% <u>coinsurance</u>
	Inpatient services	\$750 <u>copay</u> per admission	\$750 <u>copay</u> per admission	Not Covered	None
If you are pregnant	Office visits	No Charge	No Charge	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply.
	Childbirth/delivery professional services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	\$750 <u>copay</u> per admission	Not Covered	Not Covered	Additional <u>copays</u> , <u>deductibles</u> , <u>coinsurance</u> may apply.
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Not Covered	None
	<u>Rehabilitation services</u>	\$75 <u>copay</u> per outpatient visit	\$75 <u>copay</u> per outpatient visit	Not Covered	Limits per calendar year: Physical & Occupational 44 visits each. Pulmonary: 20 visits; Speech & Cardiac: Unlimited
	<u>Habilitation services</u>	\$75 <u>copay</u> per outpatient visit	\$75 <u>copay</u> per outpatient visit	Not Covered	Limits per calendar year: Physical & Occupational: 44 visits each. Speech: Unlimited Cost share applies for outpatient services only.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with a referral (You will pay the least)	Network Provider without referral	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	\$750 copay per admission	\$750 copay per admission	Not Covered	Skilled nursing is limited to 100 days per calendar year. (Inpatient Rehabilitation and Habilitation limited to 60 days each).
	Durable medical equipment	20% coinsurance	20% coinsurance	Not Covered	None
	Hospice services	0% coinsurance	0% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	\$30 copay per visit, deductible does not apply	\$30 copay per visit, deductible does not apply	Not Covered	One exam every 12 months.
	Children's glasses	50% coinsurance	50% coinsurance	Not Covered	One pair every 12 months.
	Children's dental check-up	0% coinsurance	0% coinsurance	Not Covered	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/oqa-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, kwijigo 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	\$ 3,500
■ Specialist copayment	\$75
■ Hospital (facility) copayment	\$750
■ 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
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In this example, Peg would pay:

Cost Sharing

Deductibles	\$3,500
Copayments	\$700
Coinsurance	\$30

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$4,290
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Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$ 3,500
■ Specialist copayment	\$75
■ Hospital (facility) copayment	\$750
■ 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
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In this example, Joe would pay:

Cost Sharing

Deductibles	\$3,500
Copayments	\$1,300
Coinsurance	\$10

What isn't covered

Limits or exclusions	\$30
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The total Joe would pay is	\$4,840
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$ 3,500
■ Specialist copayment	\$75
■ Hospital (facility) copayment	\$750
■ 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
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In this example, Mia would pay:

Cost Sharing

Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$1,900
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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 معرف 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. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, 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.

ចំណាំ: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សូមជួយការណ៍យើងដោយទំនុកចិត្ត គឺមានសំបុត្រអ្នកស្រុកសំបុត្រទៅលេខទំនុកចិត្ត 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 yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shq'odí ninaaltsoos nitl'izi bee nééhozinígíí bine'déé' t'áá jíik'ehgo béesh 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.

ध्यान आपो: જો તમ ે ગજુ રાતી (Gujarati) બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વાવના મલ્ ય ે પ્રાપ્ય છે. કૃપા કરી તમારા આઇડન્ ટીફિકેશન કાડ પર આપેલા ટોલ-ફી નંબર પર કોલ કરો.