This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.myuhc.com** or by calling **1-800-815-8958.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $500 Indiv / $1,000 Family Per policy year. Does not apply to copays, prescription drugs, and services listed below as "No Charge".	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Network: $4,500 Indiv/ $9,000 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the insurer pays ?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers, see www.myuhc.com or call 1-800-815-8958.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. Written approval is required to see a specialist.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-815-8958 or visit us at www.myuhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan only covers services if rendered by network **providers**. Exceptions include emergency services as described in your policy.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Designated Network Provider	Network Provider	Preferred and Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	$15 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$30 copay per visit	$30 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$15 copay per visit	$15 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services.
	Preventive care/screening/ immunization	No Charge	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider /Physician's Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Free Standing Provider /Physician's Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider /Physician's Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Free Standing Provider /Physician's Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Designated Network Provider	Network Provider	Preferred and Non-Network Provider	
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com	Tier 1 - Your Lowest-Cost Option	Not Applicable	Retail : $10 copay. Mail-Order: $25 copay. Specialty Drugs at Retail: $10 copay.	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 Pre-Authorization 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. Tier 1 contraceptives are covered at No Charge. 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 co-ins may be applied.
	Tier 2 - Your Midrange-Cost Option	Not Applicable	Retail : 20 % co-ins with a $100 copay max. Mail-Order: 20 % co-ins with a $250 copay max. Specialty Drugs at Retail: 20 % co-ins with a $100 max.	Not Covered	
	Tier 3 - Your Highest-Cost Option	Not Applicable	Retail : 40 % co-ins with a $300 copay max. Mail-Order: 40 % co-ins with a $750 copay max. Specialty Drugs at Retail: 40 % co-ins with a $300 max.	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	Not Applicable	

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Designated Network Provider	Network Provider	Preferred and Non-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Ambulatory Surg Center / Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	20% co-ins, after ded	20% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	20% co-ins, after ded	20% co-ins, after ded	20% co-ins, after ded	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	20% co-ins, after ded	None
	Urgent care	20% co-ins, after ded	20% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	20% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	20% co-ins, after ded	20% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$30 copay per visit	$30 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	20% co-ins, after ded	20% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$30 copay per visit	$30 copay per visit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Designated Network Provider	Network Provider	Preferred and Non-Network Provider	
	Substance use disorder inpatient services	20% co-ins, after ded	20% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	20% co-ins, after ded	20% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	20% co-ins, after ded	20% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	20% co-ins, after ded	Not Covered	Limited to 90 visits up to 4 hours per visit per "episode of care".
	Rehabilitation services	$15 copay per outpatient visit	$15 copay per outpatient visit	Not Covered	Physical, Speech, Occupational, Pulmonary unlimited. Cardiac limited to 90 visits per policy period.
	Habilitative services	$15 copay per outpatient visit	$15 copay per outpatient visit	Not Covered	None
	Skilled nursing care	20% co-ins, after ded	20% co-ins, after ded	Not Covered	Nursing limited to 60 days per policy period. (Inpatient Rehabilitation limited to 90 days).
	Durable medical equipment	20% co-ins, after ded	20% co-ins, after ded	Not Covered	Covers 1 per type of DME (including replace) every 2 years.
	Hospice service	20% co-ins, after ded	20% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$15 copay per visit	$15 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	Not Covered	Cleanings covered 2 times per 12 months. Additional limitations may apply.

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services).

- Acupuncture - limitations may apply
- Chiropractic Services
- Hearing aids - limitations may apply
- Infertility treatment - limitations may apply

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the District of Columbia Department of Insurance, Securities, and Banking at 202-727-8000 or visit disr.washingtondc.gov/disr/site. Additionally, a consumer assistance program can help you file your appeal. Contact DC Office of the Health Care Ombudsman and Bill of Rights at 1-877-685-6391 or visit healthcareombudsman@dc.gov.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.

若需要中文协助，请拨打您会员卡上的电话号码。

Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih

Para sa tulong sa Tagalog, tawagan ang numero sa iyong ID card.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $5,420**
- **Patient pays $2,120**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Co-pays	$20
Co-insurance	$1,400
Limits or exclusions	$200
Total	**$2,120**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $4,020**
- **Patient pays $1,380**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Co-pays	$800
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,380**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✱ **No .** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✱ **No .** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes .** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes .** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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