

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 welcometouhc.com or by calling 1-800-996-2078.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible? | Network: \$1,250 Individual / \$2,500 Family Non-Network: \$2,500 Individual / \$5,000 Family Per calendar year. Copays, Prescription drugs, and services listed below as "No Charge" do not apply to the deductible . | 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. | 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? | Network: \$3,000 Individual / \$6,000 Family Non-Network: \$6,000 Individual / \$12,000 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, and penalties for failure to obtain Pre-notification for services. | 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 plan 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 myuhc.com or call 1-800-996-2078. | 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? | No. | You can see the specialist you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services . |

Questions: Call 1-800-996-2078 or visit us at welcometouhc.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 cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.



| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---------------------------|--|--|--|--|
| | Primary care visit to treat an injury or illness | \$30 copay per visit. | 40% co-ins after ded. | If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. |
| | Specialist visit | Premium Designated: \$35 copay per visit. Non Premium Designated: \$55 copay. | 40% co-ins after ded. | If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. |
| | Other practitioner office visit | \$55 copay per visit. | 40% co-ins after ded. | Benefits include diagnosis and related services and are limited to one visit and treatment per day. Cost share applies to manipulative (Spinal) services only and is limited to \$500 per calendar year. |
| | Preventive care / screening / immunization | No Charge | 40% co-ins after ded. | Includes preventive health services specified in the health care reform law. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% co-ins after ded. | 40% co-ins after ded. | None |
| | Imaging (CT / PET scans, MRIs) | 20% co-ins after ded. | 40% co-ins after ded. | None |
| | Tier 1 – Your Lowest-Cost Option | Retail 31 day: \$10 copay Mail-Order: \$20 copay Retail 90 day: \$20 | Retail 31 day: 50% co-ins Retail 90 day: 50% co-ins | 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, |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|----------------------|--|--|--|--|
| | | copay Diabetic Pharmacy: 31&90 day: No Charge | | including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-notification requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. |
| | Tier 2 – Your Midrange-Cost Option | Retail 31 day: \$35 copay Mail-Order: \$70 copay Retail 90 day: \$70 copay Diabetic Pharmacy: 31 day: \$10 copay 90 day; \$20 copay | | |
| | Tier 3 – Your Highest-Cost Option | Retail 31 day: \$65 copay Mail-Order: \$130 copay Retail 90 day: \$130 copay Diabetic Pharmacy: 31 day: \$20 copay 90 day: \$40 copay | Retail 31 day: 50% co-ins Retail 90 day: 50% co-ins | |
| | Tier 4 – Additional High-Cost Options | Retail 31 day: \$100 copay Mail-Order: \$200 copay Retail 90 day: \$200 copay | | |
| | Facility fee (e.g., ambulatory surgery center) | 20% co-ins after ded. | 40% co-ins after ded. | None |
| | Physician / surgeon fees | 20% co-ins after ded. | 40% co-ins after ded. | None |

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|----------------------------|--|---|---|---|
| | Emergency room services | 20% co-ins after ded. | *20% co-ins after ded. | *Network deductible applies |
| | Emergency medical transportation | 20% co-ins after ded. | *20% co-ins after ded. | *Network deductible applies |
| | Urgent care | \$50 copay per visit. | 40% co-ins after ded. | If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply. |
| | Facility fee (e.g., hospital room) | 20% co-ins after ded. | 40% co-ins after ded. | Pre-notification is required non-network or benefit reduces to 50% of eligible expenses. |
| | Physician / surgeon fees | 20% co-ins after ded. | 40% co-ins after ded. | None |
| | Mental / Behavioral health outpatient services | \$30 copay per visit. | 40% co-ins after ded. | None |
| | Mental / Behavioral health inpatient services | 20% co-ins after ded. | 40% co-ins after ded. | None |
| | Substance use disorder outpatient services | \$30 copay per visit. | 40% co-ins after ded. | None |
| | Substance use disorder inpatient services | 20% co-ins after ded. | 40% co-ins after ded. | None |
| If you are pregnant | Prenatal and postnatal care | 20% co-ins after ded. | 40% co-ins after ded. | Additional copays, deductibles, or co-ins may apply depending on services rendered. |
| | Delivery and all inpatient services | 20% co-ins after ded. | 40% co-ins after ded. | Pre notification may be required for longer lengths of stay that exceed the Newborns' and Mothers' Health Protection Act of 1996. |
| | Home health care | 20% co-ins after ded. | 40% co-ins after ded. | |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|----------------------|---------------------------|---|---|--|
| | | | | per plan year. |
| | Rehabilitation services | 20% co-ins after ded. | 40% co-ins after ded. | Limits per calendar year: physical, speech, occupational – 10 visits; cardiac – post cochlear implant aural, pulmonary rehab, cardiac rehab therapy – Unlimited visits. |
| | Habilitative services | 20% co-ins after ded. | 40% co-ins after ded. | Limits are combined with Rehabilitation Services limits listed above. |
| | Skilled nursing care | 20% co-ins after ded. | 40% co-ins after ded. | Pre-notification is required non-network or benefits reduces to 50% of eligible expenses. Any combination of Network Benefits and Non-Network Benefits for Inpatient Rehabilitation is limited to 60 days per calendar year. Skilled nursing has unlimited visits. |
| | Durable medical equipment | 20% co-ins after ded. | 40% co-ins after ded. | |
| | Hospice service | 20% co-ins after ded. | 40% co-ins after ded. | Limited to 180 days per calendar year. Inpatient Pre-notification is required for non-network or benefit reduces to 50% of eligible expenses. |
| | Eye exam | Not Covered | Not Covered | No coverage for eye exams. |
| | Glasses | Not Covered | Not Covered | No coverage for glasses. |
| | Dental check-up | Not Covered | Not Covered | No coverage for dental check-up. |

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Employee & Family

Plan Type: PS1

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 <u>excluded services</u> .) | | | |
|---|---|--|---|
| <ul style="list-style-type: none"> Bariatric surgery Cosmetic surgery | <ul style="list-style-type: none"> Dental care (Adult/Child) Glasses (Adult/Child) Hearing aids Infertility treatment | <ul style="list-style-type: none"> Long-term care Non-emergency care when traveling outside the U.S. Private-duty nursing | <ul style="list-style-type: none"> Routine eye care (Adult/Child) Routine foot care Weight loss programs |
| Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.) | | | |
| <ul style="list-style-type: none"> Chiropractic care Acupuncture Services | | | |

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 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.

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 the Member Service number listed on the back of your ID card or visit www.myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-996-2078.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-996-2078.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-996-2078.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-996-2078.

-----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.



- Amount owed to providers: \$7,540
- Plan pays \$5,020
- Patient pays \$2,520

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 |

Patient pays:

| | |
|----------------------|---------|
| Deductibles | \$1,300 |
| Copays | \$20 |
| Coinsurance | \$1,000 |
| Limits or exclusions | \$200 |



- Amount owed to providers: \$5,400
- Plan pays \$3,360
- Patient pays \$2,040

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 |

Patient pays:

| | |
|----------------------|----------------|
| Deductibles | \$1,000 |
| Copays | \$1,000 |
| Coinsurance | \$0 |
| Limits or exclusions | \$40 |
| Total | \$2,040 |

Questions and answers about Coverage Examples:

| | | |
|---|---|---|
| <p>What are some of the assumptions behind the Coverage Examples?</p> <ul style="list-style-type: none"> Costs don't include premiums. Sample care costs are based on national averages supplied to 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 excluded. 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. | <p>What does a Coverage Example show?</p> <p>For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance 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.</p> | <p>Can I use Coverage Examples to compare plans?</p> <p>✓ 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.</p> |
| | <p>Does the Coverage Example predict my own care needs?</p> <p>✗ 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.</p> | <p>Are there other costs I should consider when comparing plans?</p> <p>✓ 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 copayments, deductibles, and coinsurance. 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.</p> |
| | <p>Does the Coverage Example predict my future expenses?</p> <p>✗ 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.</p> | |

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