



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 ?	\$2,400/individual or \$4,800/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, 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 – \$400 individual / \$800 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 \$9,200 individual / \$18,400 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$60 <u>copay</u> / office visit and No charge / Virtual visits by a designated virtual <u>participating provider</u> ; <u>deductible</u> does not apply	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductibles</u> or <u>coinsurance</u> may apply.
	<u>Specialist</u> visit	\$95 <u>copay</u> / visit; <u>deductible</u> does not apply	Not covered	Member is required to obtain a <u>referral</u> to <u>specialist</u> or other licensed health care practitioner, except for OB/GYN <u>Physician services</u> , reproductive health care services within the <u>Participating Medical Group</u> and Emergency / Urgently needed services. If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductibles</u> or <u>coinsurance</u> may apply.
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need 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)	Lab \$45 <u>copay</u> / test Radiology (Standard) \$45 <u>copay</u> / test; <u>deductible</u> does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$400 <u>copay</u> / test; <u>deductible</u> 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	\$20 <u>copay</u> / prescription retail \$40 <u>copay</u> / prescription mail order \$20 <u>copay</u> / <u>specialty drugs</u> ; <u>deductible</u> does not apply	Not covered	<u>Participating Provider</u> 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 <u>specialty drugs</u> , from a pharmacy designated by us. When applicable: Mail-Order <u>Specialty drugs</u> Up to a 31 day supply. All limits are unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <u>Copayment</u> Maximum of \$250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a <u>plan</u> design not defined as a High <u>Deductible Health Plan</u> regardless of any <u>Deductible</u> . 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 <u>plan</u> .
	Tier 2	\$80 <u>copay</u> / prescription retail \$160 <u>copay</u> / prescription mail order \$150 <u>copay</u> / <u>specialty drugs</u>	Not covered	
	Tier 3	\$125 <u>copay</u> / prescription retail \$250 <u>copay</u> / prescription mail order \$250 <u>copay</u> / <u>specialty drugs</u>	Not covered	
	Tier 4	25% <u>coinsurance</u> / prescription retail up to a \$250 <u>copay</u> max per prescription 25% <u>coinsurance</u> / prescription mail order up to a \$500 <u>copay</u> max per prescription 25% <u>coinsurance</u> / <u>specialty drugs</u> up to a \$250 <u>copay</u> max per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	40% <u>coinsurance</u> ; <u>deductible</u> does not apply	Not covered	
If you need immediate medical attention	Emergency room care	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Emergency medical transportation	\$100 <u>copay</u> / trip; <u>deductible</u> does not apply	\$100 <u>copay</u> / trip; <u>deductible</u> does not apply	
	Urgent care	\$60 <u>copay</u> / visit; <u>deductible</u> does not apply	\$125 <u>copay</u> / visit; <u>deductible</u> does not apply	If you receive services in addition to <u>urgent care</u> , additional <u>copayments</u> , <u>deductibles</u> or <u>coinsurance</u> may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	40% <u>coinsurance</u> ; <u>deductible</u> 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	\$60 <u>copay</u> / office visit and No charge for all other outpatient services; <u>deductible</u> does not apply	Not covered	None
	Inpatient services	40% <u>coinsurance</u>	Not covered	
If you are pregnant	Office visits	No charge; <u>deductible</u> does not apply	Not covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Routine pre-natal care and first postnatal visit is covered at No charge. Depending on the type of services, additional <u>copayments</u> , <u>deductibles</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge; <u>deductible</u> does not apply	Not covered	
	Childbirth/delivery facility services	40% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	Home health care	\$60 <u>copay</u> / visit; <u>deductible</u> 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	\$60 <u>copay</u> / visit; <u>deductible</u> does not apply	Not covered	None
	Habilitative services	\$60 <u>copay</u> / visit; <u>deductible</u> does not apply	Not covered	
	Skilled nursing care	40% <u>coinsurance</u>	Not covered	Up to 100 days per benefit period.
	Durable medical equipment	\$70 <u>copay</u> / item; <u>deductible</u> does not apply	Not covered	None
	Hospice services	No charge; <u>deductible</u> does not apply	Not covered	If inpatient admission, subject to inpatient <u>copayments</u> , <u>deductibles</u> or <u>coinsurance</u> .
If your child needs dental or eye care	Children's eye exam	No charge; <u>deductible</u> does not apply	Not covered	1 exam per year.
	Children's glasses	40% <u>coinsurance</u> ; <u>deductible</u> does not apply	Not covered	One pair every 12 months.
	Children's dental check-up	No charge; <u>deductible</u> 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](#).)

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|--|--|--|
| <ul style="list-style-type: none">• Cosmetic surgery• Dental care (Adult)• 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 foot care• Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---|--|--|
| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery | <ul style="list-style-type: none">• Chiropractic care• Hearing aids | <ul style="list-style-type: none">• Routine eye care (Adult) |
|---|--|--|

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): Dinekehgo shika at'ohwol ninisingo, kwijigo 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 [provider](#) pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$2,400
■ Specialist copayment	\$95
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles*	\$2,400
Copayments	\$100
Coinsurance	\$2,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,960

Managing Joe's Type 2 Diabetes

(a year of routine [participating provider](#) care of a well-controlled condition)

■ The plan's overall deductible	\$2,400
■ Specialist copayment	\$95
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$400
Copayments	\$2,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,400

Mia's Simple Fracture

([participating provider](#) [emergency room](#) visit and follow up care)

■ The plan's overall deductible	\$2,400
■ Specialist copayment	\$95
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$0
Copayments	\$500
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000

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.