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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: For participating providers $2,000 individual / $4,000 family. Prescription Drugs In-Network: $2,000/individual, $4,000/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?	Medical: Copayments for certain services, premiums, balance-billing charges, prescription drug expenses, and health care this plan doesn't cover. Prescription Drug: premiums, balance-billing charges, medical expenses, 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.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay / office visit and $20 copay / Virtual visits by a designated virtual participating provider	Not covered	If you receive services in addition to office visit, additional copayments or coinsurance may apply.
	Specialist visit	$40 copay / visit	Not covered	Member is required to obtain a referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services, reproductive health care services within the Participating Medical Group and Emergency / Urgently needed services. If you receive services in addition to office visit, additional copayments or coinsurance may apply.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$50 copay / test	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.optumrx.com	Generic drugs (Formulary generic drugs)	Retail: $10 copayment/script. Mail order: $20 copayment/script	Not covered (limited exceptions for emergency prescriptions)	• Deductible does not apply. Cost sharing counts toward the out-of-pocket limit for prescription drugs (not the medical limit). • Limited to a 30-day supply at retail and a 90-day supply for mail-order. • Mail Order is required for maintenance medications after the third fill at a retail pharmacy. After the 3rd refill at retail, you will be charged 2 copayments/fill. • No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate). • Some prescription drugs are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements. • Certain over-the-counter (OTC) and prescription drugs are payable at no charge with a prescription.
	Preferred Brand drugs (Formulary brand)	Retail: $20 copayment/script. Mail order: $40 copayment/script		
	Non-Preferred Brand drugs (Non-formulary generic or Non-formulary brand drugs)	If preauthorization is obtained, paid as a formulary drug		
	Specialty drugs	Same copayments as retail formulary generic and retail formulary brand drugs copayments.	Not covered	• Deductible does not apply. Cost sharing counts toward the out-of-pocket limit for prescription drugs (not the medical limit). • Specialty drugs must be purchased through the Optum Specialty Pharmacy after the first fill at retail. Call (855) 798-5682 for information. • Limited to a 30-day supply.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay / admit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$100 copay / visit	$100 copay / visit	Copayment waived if admitted.
	Emergency medical transportation	$50 copay / trip	$50 copay / trip	None
	Urgent care	$20 copay / visit	$100 copay / visit	If you receive services in addition to urgent care, additional copayments or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay / day	Not covered	Copayment applies to a maximum of 3 days per stay.
	Physician/surgeon fees	No charge	Not covered	None

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	$40 copay / office visit and No charge for all other outpatient services	Not covered	Substance abuse outpatient and inpatient services are covered at No charge.
	Inpatient services	$250 copay / day	Not covered	Copayment applies to a maximum of 3 days per stay.
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to certain preventive services. Routine pre-natal care and first postnatal visit is covered at No charge.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$500 copay / day	Not covered	Copayment applies to a maximum of 3 days per stay. Depending on the type of services, additional copayments or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	$10 copay / visit	Not covered	Limited to 100 visits per calendar year.
	Rehabilitation services	$20 copay / visit	Not covered	Coverage is limited to physical, occupational, and speech therapy.
	Habilitative services	Not covered	Not covered	No coverage for Habilitative services.
	Skilled nursing care	$200 copay / day	Not covered	Copayment applies to a maximum of 3 days per stay. Up to 100 days per benefit period.
	Durable medical equipment	$50 copay / item	Not covered	None
	Hospice services	No charge	Not covered	If inpatient admission, subject to inpatient copayments or coinsurance.
If your child needs dental or eye care	Children's eye exam	$20 copay / visit	Not covered	Additional coverage available under separate vision plan available through the Fund, if elected.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	If you elect dental coverage, it will be available under a separate dental plan.

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 and Child) (available under separate dental plan)	• Habilitative services • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Weight loss programs
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	• Routine eye care (Adult) (additional coverage available under separate vision plan)

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 http://www.healthhelp.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 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 http://www.healthhelp.ca.gov.

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 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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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 participating provider pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$500/day
Other coinsurance	0%

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	$0
Copayments	$580
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$590

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

The plan's overall	$0
Specialist copayment	$40
Hospital (facility)	$500/day
Other coinsurance	0%

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	$0
Copayments	$1,330
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,350

Mia's Simple Fracture
(participating provider emergency room visit and follow up care)

The plan's overall	$0
Specialist copayment	$40
Hospital (facility)	$500/day
Other coinsurance	0%

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	$0
Copayments	$460
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$460

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.

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