



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 1-800-996-0271.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred: \$1,000 Individual / \$3,000 Family Non-Preferred: \$2,000 Individual / \$6,000 Family Per calendar 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 Common Medical Events chart 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 Common Medical Events chart for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Preferred: \$1,000 Individual / \$3,000 Family Non-Preferred: \$7,000 Individual / \$16,000 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, prescription drugs, copays, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain Pre-Authorization 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 Common Medical Events chart describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use preferred providers?	Yes, this plan uses preferred providers . If you use a non-preferred provider your cost may be more. For a list of preferred providers , see www.myuhc.com or call 1-800-996-0271 for a list of preferred providers .	If you use a preferred doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your preferred doctor or hospital may use a non-preferred provider for some services. Plans use the term preferred, preferred , or participating for preferred providers . See the Common Medical Events chart for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist .	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 under Services Your Plan Does NOT Cover. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-996-0271 or visit us at www.myuhc.com. If you aren't clear about any of the terms used in this form, see the Glossary.

You can view the Glossary at www.dol.gov/ebsa/healthreform or call the phone number above to request a copy. **This is only a summary.**

It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.



- **Co-payments (copays)** 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 a non-preferred **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-preferred 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 may encourage you to use preferred **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 copay per visit	20% co-ins, after ded.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Pre-authorization is required for non-preferred services for Genetic Testing – BRCA or benefit reduces to 50%.
	Specialist visit	\$55 copay per visit	20% co-ins, after ded.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Pre-authorization is required for non-preferred services for Genetic Testing – BRCA or benefit reduces to 50%.
	Other practitioner office visit	\$35 copay per visit of Manipulative (Chiropractic) services	20% co-ins for Manipulative (Chiropractic) services, after ded.	Limited to 20 visits of Manipulative (Chiropractic) services per calendar year. Pre-authorization is required for non-preferred services or benefit reduces to 50%.
	Preventive care / screening / immunization	No Charge	20% co-ins*, after ded.	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	0% co-ins, after ded.	20% co-ins, after ded.	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
	Imaging (CT / PET scans, MRIs)	\$250 copay per service	20% co-ins, after ded.	None
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	Retail: \$15 copay Mail-Order: \$37.50 copay	Retail: \$15 copay Mail-Order: 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. If you use a non-preferred 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: \$40 copay Mail-Order: \$100 copay	Retail: \$40 copay Mail-Order: Not Covered	
	Tier 3 – Your Highest-Cost Option	Retail: \$75 copay Mail-Order: \$187.50 copay	Retail: \$75 copay Mail-Order: Not Covered	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-ins, after ded.	20% co-ins, after ded.	Pre-Authorization is required for non-preferred services or benefit reduces to 50%.
	Physician / surgeon fees	0% co-ins, after ded.	20% co-ins, after ded.	None
If you need immediate medical attention	Emergency room services	\$250 copay per visit	Same as Preferred	Copay is waived if you are admitted for Inpatient stay directly from the Emergency Room. Notification is required if confined in a non-Preferred Hospital.
	Emergency medical transportation	0% co-ins, after ded.	Same as Preferred	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
	Urgent care	\$75 copay per visit	20% co-ins, after ded.	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins, after ded.	20% co-ins, after ded.	Pre-Authorization is required for non-preferred services or benefit reduces to 50%.
	Physician / surgeon fees	0% co-ins, after ded.	20% co-ins, after ded.	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	\$35 copay per visit	20% co-ins, after ded.	Pre-Authorization is required for non-preferred services or benefit reduces to 50%. See your policy or plan document for additional information about EAP benefits.
	Mental / Behavioral health inpatient services	0% co-ins, after ded.	20% co-ins, after ded.	Pre-Authorization is required for non-preferred services or benefit reduces to 50%. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder outpatient services	\$35 copay per visit	20% co-ins, after ded.	Pre-Authorization is required for non-preferred services or benefit reduces to 50%. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder inpatient services	0% co-ins, after ded.	20% co-ins, after ded.	Pre-Authorization is required for non-preferred services or benefit reduces to 50%. See your policy or plan document for additional information about EAP benefits.
If you become pregnant	Prenatal and postnatal care	0% co-ins, after ded.	20% co-ins, after ded.	Additional copays, deductibles, or co-ins may apply. Preferred routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	0% co-ins, after ded.	20% co-ins, after ded.	Inpatient Pre-Authorization may apply for non-preferred services or benefit

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
				reduces to 50%.
If you need help recovering or have other special health needs	Home health care	0% co-ins, after ded.	20% co-ins, after ded.	Limited to 60 visits per calendar year. Pre-Authorization is required for non-preferred services or benefit reduces to 50%.
	Rehabilitation services	\$35 copay per outpatient visit	20% co-ins, after ded.	Depending on the type of therapy, there is a limit of 20-36 visits per calendar year.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation services.
	Skilled nursing care	0% co-ins, after ded.	20% co-ins, after ded.	Limited to 60 days per calendar year. (combined with Inpatient Rehabilitation). Pre-Authorization is required for non-preferred services or benefit reduces to 50%.
	Durable medical equipment	0% co-ins, after ded.	20% co-ins, after ded.	\$2,500 maximum per calendar year if the benefit/device is determined to be non-essential. Pre-Authorization is required for non-preferred services for DME over \$1,000 or no coverage. Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice service	0% co-ins, after ded.	20% co-ins, after ded.	Inpatient Pre-Authorization is required for non-preferred services or benefit reduces to 50%.
If your child needs dental or eye care	Eye exam	\$35 copay per visit	20% co-ins, after ded.	Limited to 1 exam every 2 years.
	Glasses	Not Covered	Not Covered	No coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

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.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult/Child) 	<ul style="list-style-type: none"> • Glasses • Habilitation services • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • 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 - may be covered with limitations 	<ul style="list-style-type: none"> • Hearing aids - may be covered with limitations 	<ul style="list-style-type: none"> • Routine eye care (Adult) - may be covered with limitations

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 <http://www.dol.gov/ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit <http://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 or the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or Georgia Office of Insurance & Safety Fire Commissioner at 1-404-656-2070 or visit <http://www.oci.ga.gov/home.aspx>.

Additionally, a consumer assistance program may help you file your appeal. Contact Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division at 1-800-656-2298 or visit <http://www.oci.ga.gov/ConsumerService/Home.aspx>. 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>.

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-996-0271.

如果需要中文的帮助, 请拨打这个号码 1-800-996-0271.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne! 1-800-996-0271.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-996-0271.

-----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 \$6,340
- Patient Pays \$1,200

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	\$1,000
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$200
Total	\$1,200

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

- Amount owed to providers: \$5,400
- Plan Pays \$4,320
- Patient Pays \$1,080

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	\$700
Co-pays	\$300
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$1,080

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 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-preferred providers. If the patient had received care from out-of-preferred 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, 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.</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 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.</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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