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 1-866-633-2446.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$750** Individual / **$1,500** Family Non-Network: **$1,500** Individual / **$3,000** 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 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?	Network: **$3,250** Individual / **$6,500** Family Non-Network: **$5,500** Individual / **$11,000** 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-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. This policy has no overall annual limit on the amount it will pay each year.	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 a network of providers?	Yes, this plan uses network **providers**. If you use a non-network **provider** your cost may be more. For a list of network **providers**, see **myuhc.com** or call **1-866-633-2446** for a list of network **providers**.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network**. 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**.

- **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-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-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 may encourage you to use network **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
		Network Provider	Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Covered persons less than age 19:** $0 copay per visit **All other Covered Persons:** **Network & Designated Network:** $20 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. Pre-authorization is required non-network for Genetic Testing – BRCA or the lesser of 50% of eligible expenses or $500.
	Specialist visit	**Designated Network:** $20 copay per visit **Network:** $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. Pre-authorization is required non-network for Genetic Testing – BRCA or the lesser of 50% of eligible expenses or $500.
	Other practitioner office visit	$20 copay per visit of Manipulative (Chiropractic) services	40% co-ins after ded. for Manipulative (Chiropractic) services	Limited to 20 visits of Manipulative (Chiropractic) services per Calendar year. Pre-Authorization is required non-network or the lesser of 50% of eligible expenses or $500.
	Preventive care / screening / immunization	No Charge	30% 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)	No Charge	30% co-ins after ded.	Pre-Authorization is required non-network for sleep studies or the lesser of 50% of eligible expenses or $500.
	Imaging (CT / PET scans, MRIs)	20% co-ins after ded.	40% co-ins after ded.	Pre-Authorization is required non-network or the lesser of 50% of eligible expenses or $500..
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest-Cost Option	Retail: $10 copay Mail-Order: $20 copay	Retail: $10 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

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
More information about **prescription drug coverage** is available at **myuhc.com**	Tier 2 – Your Midrange-Cost Option	Retail: $30 copay Mail-Order: $60 copay	Retail: $30 copay Mail-Order: Not Covered	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-network 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. Out of Pocket limit: $6,350 Individual / $12,700 Family.
	Tier 3 – Your Highest-Cost Option	Retail: $50 copay Mail-Order: $100 copay	Retail: $50 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)	20% co-ins after ded.	40% co-ins after ded.	Pre-Authorization is required non-network or the lesser of 50% of eligible expenses or $500.
	Physician / surgeon fees	**Designated Network:** Primary Care Visits: 20% co-ins after ded. Specialist Care Visits: 20% co-ins after ded. **Network:** Primary Care Visits: 20% co-ins after ded. Specialist Care Visits: 20% co-ins after ded.	40% co-ins after ded.	None
If you need immediate medical attention	Emergency room services	$100 copay per visit	Same as Network	Copay is waived if you are admitted for Inpatient stay directly from the Emergency Room. Notification is required if confined in a non-Network Hospital.
	Emergency medical transportation	20% co-ins after ded.	Same as Network	None
	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.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins after ded.	40% co-ins after ded.	Pre-Authorization is required non-network or the lesser of 50% of eligible expenses or $500.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
	Physician / surgeon fees	**Designated Network:** Primary Care Visits:20% co-ins after ded. Specialist Care Visits:20% co-ins after ded. **Network:** Primary Care Visits: 20% co-ins after ded. Specialist Care Visits: 20% co-ins after ded.	40% co-ins after ded.	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	$20 copay per visit	40% co-ins after ded.	Pre-Authorization is required non-network for certain services or the lesser of 50% of eligible expenses or $500. See your policy or plan document for additional information about EAP benefits.
	Mental / Behavioral health inpatient services	20% co-ins after ded.	40% co-ins after ded.	Pre-Authorization is required non-network or the lesser of 50% of eligible expenses or $500. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder outpatient services	$20 copay per visit	40% co-ins after ded.	Pre-Authorization is required non-network for certain services or the lesser of 50% of eligible expenses or $500. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder inpatient services	20% co-ins after ded.	40% co-ins after ded.	Pre-Authorization is required non-network or the lesser of 50% of eligible expenses or $500. See your policy or plan document for additional information about EAP benefits.
If you become 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. Your cost in this category includes Physician Delivery Charges. Network routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	20% co-ins after ded.	40% co-ins after ded.	Your cost for inpatient services only. Delivery see above. Inpatient Pre-Authorization may apply non-network or the lesser of 50% of eligible expenses or $500.

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
If you need help recovering or have other special health needs	Home health care	20% co-ins after ded.	40% co-ins after ded.	Limited to 60 visits per Calendar year. Pre-Authorization is required non-network or the lesser of 50% of eligible expenses or $500.
	Rehabilitation services	$20 copay per outpatient visit	40% co-ins after ded.	Depending on the type of therapy, there may be a limit of 20-36 visits per Calendar year. Pre-Authorization required for Physical, Occupational and Speech non-network or the lesser of 50% of eligible expenses or $500.
	Habilitative services	$20 copay per outpatient visit	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.	Limited to 60 days per Calendar year. (combined with Inpatient Rehabilitation) Pre-Authorization is required non-network or the lesser of 50% of eligible expenses or $500.
	Durable medical equipment	20% co-ins after ded.	40% co-ins after ded.	Pre-Authorization is required non-network for DME over $1,000 or benefit reduces to the lesser of 50% of eligible expenses or $500. Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice service	20% co-ins after ded.	40% co-ins after ded.	Inpatient Pre-Authorization is required for non-network or the lesser of 50% of eligible expenses or $500.
If your child needs dental or eye care	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.

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.)			
• Acupuncture • Bariatric surgery • Cosmetic surgery	• Dental care (Adult/Child) • Glasses (Adult/Child) • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• 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.)			
• Chiropractic care – limitations may apply	• Habilitative services – limitations may apply	• Hearing aids – 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 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 Oklahoma Insurance Department at 1-800-522-0071 or visit http://www.ok.gov/oid/.

Additionally, a consumer assistance program may help you file your appeal. Contact Oklahoma Insurance Department at 1-800-522-0071 (in state only) or 1-405-521-2828 or visit http://www.ok.gov/oid/Consumers/Consumer_Assistance/index.html. 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:

Para obtener asistencia en Español, llame al 1-866-633-2446.
如果需要中文的帮助，请拨打这个号码 1-866-633-2446.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

----------*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** $5,320
- ☐ **Patient Pays** $2,220

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	$700
Co-pays	$20
Co-insurance	$1,200
Limits or exclusions	$200
Total	**$2,220**

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

- ☐ **Amount owed to providers:** $5,400
- ☐ **Plan Pays** $3,920
- ☐ **Patient Pays** $1,480

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	$800
Co-pays	$700
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,480**

Questions and answers about 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 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-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.

Questions: Call 1-866-633-2446 or visit us at welcometouhc.com. If you aren't clear about any of the 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. **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.