

**BEFORE THE PUBLIC UTILITIES COMMISSION
OF THE STATE OF CALIFORNIA**

Application of Suburban Water Systems
(U339W) for Authority to Increase Rates
Charged for Water Service by \$19,971,673
or 19.41% in 2027, by \$10,876,890 or
8.91% in 2028, and by \$10,831,656 or
8.15% in 2029.

Application 26-01-XXX

(Filed January 2, 2026)

DIRECT TESTIMONY OF BRIAN DEVERAUX

PUBLIC VERSION

January 2, 2026

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1 **I. INTRODUCTION**

2 Q1. Please provide your name, position, and business address.

3 A1. My name is Brian Devereux. I am a Principal in the Health and Benefits practice of
4 Mercer Health & Benefits LLC (“Mercer”). Mercer’s approximately 25,000 employees
5 are based in forty-three countries, and is a global leader in health, retirement,
6 investments, and talent. Mercer is a business of Marsh McLennan, the world’s leading
7 professional services firm in the areas of risk, strategy, and people, with 90,000
8 colleagues advise clients in 130 countries. With annual revenue of nearly \$25 billion, we
9 help corporate and public sector leaders navigate an increasingly dynamic environment
10 through four market-leading businesses: Marsh, Guy Carpenter, Mercer, and Oliver
11 Wyman. My Mercer business address is: 17901 Von Karman Avenue, Suite 1100, Irvine,
12 CA 92614.

13 Q2. Please state your educational and professional background experience.

14 A2. I graduated from San Diego State University with a Bachelor of Science degree in
15 Business Administration (Management). After working for five years in Corporate
16 Human Resources, I transitioned to the brokerage and consulting side of employee
17 benefits. I have worked for Marsh McLennan for a total of twenty-two years: two years
18 for Marsh and the past twenty years for Mercer. I am a licensed life agent and have also
19 passed my Series 6 and Series 63 license exams. With twenty-seven years of experience
20 working with employee benefit programs, ranging from 200 to 20,000+ employees, my
21 extensive knowledge regarding this subject matter aids in providing my clients with in-
22 depth analysis and strategic guidance when designing and implementing competitive
23 benefits programs.

1 **II. MEDICAL AND PRESCRIPTION DRUG PROGRAM**

2 Q3. What general areas will you address regarding medical and prescription drug insurance?

3 A3. I will describe (1) Suburban’s current medical and prescription drug program historical
4 costs and (2) Suburban’s expected future costs.

5 Q4. What type of medical and prescription drug programs does Suburban have?

6 A4. Mercer was awarded the Broker of Record (BOR) in July 2018. At that time, SouthWest
7 Water Company operated four medical programs nationwide: one fully-insured program
8 with UnitedHealthcare in California (Suburban Water Systems), one fully-insured
9 program with Blue Cross Blue Shield of Alabama; one fully-insured program with Blue
10 Cross Blue Shield of South Carolina; and one self-funded program with Blue Cross Blue
11 Shield of Texas. Following an extensive marketing campaign to consolidate the medical
12 program, UnitedHealthcare was selected to become the lone fully-insured medical carrier
13 with two Preferred Provider Organization (PPO) plans and one Health Savings Account
14 (HSA) eligible High Deductible Health Plan (HDHP) plan offered to all employees
15 nationwide. UnitedHealthcare remained the fully-insured medical carrier through
16 December 31, 2024.

17 On April 1, 2024, SouthWest Water Company and Corix Infrastructure (U.S.), Inc.
18 completed the merger of their water and wastewater businesses to create Nexus Water
19 Group, Inc. Following an extensive review and analysis of the existing benefit programs,
20 Mercer requested competitive proposals from the marketplace, to offer one set of benefits
21 to all Nexus Water Group employees. This approach increased the overall headcount
22 (from approximately 550 to approximately 1,300 benefits eligible employees), which
23 helped to mitigate risk when evaluating the core programs such as medical, dental and
24 vision. Following a marketing campaign, which included a review of both funding
25 options, Blue Cross Blue Shield of Texas was selected to become the fully insured

1 medical carrier for Nexus Water Group in 2025. Three medical plans are offered to all
2 employees nationwide: two Preferred Provider Organization (PPO) plans and one Health
3 Savings Account (HSA) eligible High Deductible Health Plan (HDHP). Current and
4 previous benefit summaries are included as Attachment 1. Nexus Water Group and
5 Mercer will analyze the group's experience and demographic factors each year, during
6 the annual renewal process, to determine if migrating from a fully-insured program to a
7 self-funded program is viable and favorable to the overall employee population.

8
9 All full-time Suburban Water Systems employees who work a minimum of thirty hours
10 per week are eligible to enroll in one of the medical insurance plans offered to employees
11 through Blue Cross Blue Shield of Texas. Former employees who are eligible to enroll in
12 COBRA, are also eligible to enroll in one of the medical insurance plan options. Please
13 note that if an employee elects to participate in the HSA medical plan, their dependents
14 are not eligible to enroll in another medical plan option (i.e. PPO). Suburban Water
15 Systems does not offer a retiree medical program.

16
17 Suburban Water Systems participates in Nexus Water Group's medical plan. Only one
18 premium rate increase is calculated for Nexus Water Group. Using the entire group's
19 employee population for underwriting (i.e. rate setting) results in less year-to-year claim
20 volatility and higher credibility assigned to the actual claims experience. Suburban Water
21 Systems is responsible for premium cost based on their employees' plan elections.

22
23 Suburban Water Systems' medical renewal is experience rated, and the upcoming 2026
24 renewal is based 87% on credibility (client's overall experience) and 13% manuals.
25 Underwriters evaluate the medical and prescription drug claims experience, combined
26 with high cost claimants (especially those that could continue into the next plan year) and
27 demographic data.

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Upon receipt of the initial renewal from the carrier, Mercer’s consulting team and actuaries review the renewal projection to determine if appropriate medical and prescription drug trends are being used, compared to Mercer’s internal data. When an account is fully-insured, and the claims experience is available (such as the case with Suburban Water Systems), Mercer’s actuaries will prepare the renewal projections, which are used to aid in the renewal negotiations. Suburban Water Systems has received overall competitive renewals, compared to the marketplace.

The following exhibit illustrates the projected plan year costs (per employee per month, or PEPM) from 2020 through 2025. These costs are compared to the data from Mercer’s National Survey of Employer-sponsored Health Plans (“Survey”). Mercer’s survey, with over 2,174 respondents in 2024, is one of the largest of its kind. It provides trends in cost and plan design and looks at employers’ strategies for managing cost and supporting employees, and how they have responded to the pandemic. Mercer shares data from our survey during our annual strategy discussion with clients, such as Suburban Water Systems, to ensure the plans being offered are competitive to “benchmarks” in the marketplace.

Year	Medical PEPM		
	UHC	California*	National*
2020	\$1,203	\$1,267	\$1,143
2021	\$1,296	\$1,369	\$1,199
2022	\$1,415	\$1,435	\$1,286
2023	\$1,475	\$1,508	\$1,377
2024	\$1,627	\$1,596	\$1,464
	BCBS of TX		
2025	\$1,572		

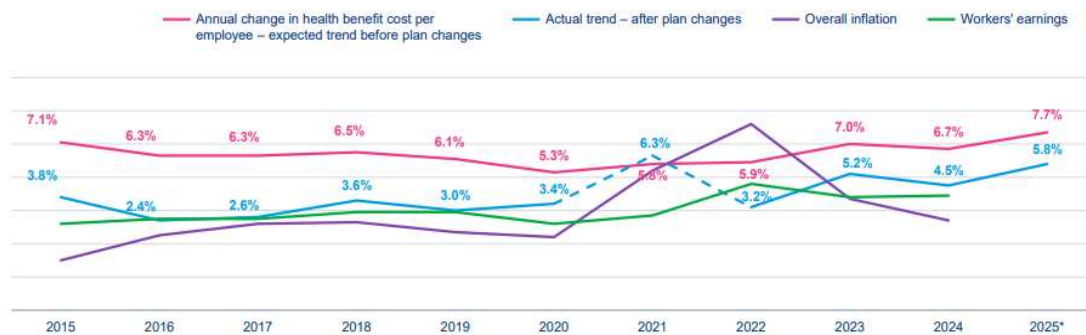
* Mercer's National Survey of Employer-sponsored Health Plans

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Q5. What has been the historical trend in employer sponsored medical/prescription drug plan premiums?

1 A5. A number of factors in today’s environment are contributing to healthcare trends and
 2 making it challenging for employers to manage benefits, including: (1) rising unit costs
 3 for healthcare; (2) affordability challenges; (3) medical advances; and (4) misaligned
 4 incentives and gaps in care. The health benefit cost trend jumped above 5.0% in 2023 and
 5 will likely remain elevated through 2026 at least. Health benefit cost trend has two
 6 primary components – the price of healthcare services and rate of utilization – and right
 7 now, both are rising. A primary driver is higher prices for healthcare services. Pandemic-
 8 related inflationary pressure continues to work its way through the healthcare system, but
 9 ongoing market consolidation is also playing a role. Utilization rates for various health
 10 services have been rising over the past few years. The lingering effect of delayed or
 11 missed care due to the COVID-19 pandemic has been a factor.

12 Since CalPERS is the largest purchaser of public health benefits in California, which
 13 covers the California state employees including the CPUC and Public Advocates
 14 (<https://www.cpuc.ca.gov/careers/employee-benefits>), many companies with California-
 15 based health insurance contracts compare the renewal increases they receive to CalPERS.
 16 On July 15, 2025, the CalPERS Board of Administration approved health plan premiums
 17 for the calendar year 2026, with an overall weighted premium increase of 8.21% (which
 18 includes HMO plan, PPO plan and Medicare plan premiums) – see Attachment 2..
 19 Members enrolled in CalPERS’ PPO plans will have an overall increase of 12.08%.
 20 CalPERS’ proposed 2026 increase is higher than Suburban’s healthcare cost increase for
 21 2026.



1 Q6. What is the projected trend in employer sponsored medical/prescription drug insurance?

2 A6. Please see the table below.

Plan	UnitedHealthcare Annual Trend Rate					BCBS of Texas	
	2020	2021	2022	2023	2024	2025	2026
Medical	9.7%	9.7%	9.3%	9.1%	8.8%	6.2%	9.8%
Prescription Drug	10.8%	10.8%	11.1%	14.1%	12.3%	12.0%	9.0%

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Medical	Historical Renewals				
	2020	2021	2022	2023	2024
UnitedHealthcare					
Fully-insured Medical	1.5%	6.9%	9.3%	6.8%	8.4%

Medical	Current	Renewal	Projected Renewals	
	2025	2026	2027	2028
Blue Cross Blue Shield of Texas*				
Fully-insured Medical	-1.6%	10.6%	10.0%	10.0%

* Implemented consolidated medical program

See Attachment 3 for renewals.

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9 Q7. What is the breakdown of cost for the employer-sponsored medical/prescription drug
10 insurance (employer vs. employee contributions)?

11 A7. Please see the table below.

Year	Medical Cost Breakdown	
	Suburban Water	Employee
2020	89.4%	10.6%
2021	90.0%	10.0%
2022	89.9%	10.1%
2023	89.6%	10.4%
2024	89.6%	10.4%
2025	83.3%	16.7%

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14 **III. DENTAL PROGRAM**

15 Q8. What general areas will you address regarding dental insurance?

16 A8. I will describe (1) Suburban’s current dental plan arrangement and historical costs and (2)
17 Suburban’s expected future costs.

1 Q9. What type of dental plan arrangement does Suburban have?

2 A9. Prior to 2025, the dental program was self-funded and offered through The Guardian. The
3 self-insured program included two components: the administrative service fee (ASO) and
4 dental claims. All full-time employees who work at the minimum of thirty (30) hours per
5 week are eligible to enroll in one of the dental insurance plans. Former employees who
6 are eligible to enroll in COBRA, are also eligible to enroll in one of the dental insurance
7 plan options. Suburban Water Systems does not offer a retiree dental program.

8 On April 1, 2024, SouthWest Water Company and Corix Infrastructure (U.S.), Inc.
9 completed the merger of their water and wastewater businesses to create Nexus Water
10 Group, Inc. Following a marketing campaign, MetLife was selected to become the fully-
11 insured dental carrier in 2025 with two Dental PPO (DPPO) plans offered to all
12 employees nationwide.

13
14 Q10. What has been Suburban’s experience with respect to its dental plan costs?

15 A10. When projecting the dental renewal each year, Mercer’s actuaries use annual dental trend
16 and include margin. The average Dental PPO trend has been consistently 5.5% for the
17 past seven years.

Plan	Annual Trend Rate						
	2020	2021	2022	2023	2024	2025	2026
Dental	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%

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21 Based on Suburban Water Systems’ dental claims experience, Mercer recommended an
22 increase to the dental budget rates in 2020. In 2021, the company opted to enhance their
23 “Buy-up” Dental PPO option, and their budget rates were adjusted accordingly to account
24 for the potential increase in claims. Based on positive claims experience, Mercer’s
25 recommendation for 2022-2024 was to maintain current budget rates. MetLife’s rates

1 included a two-year rate guarantee (January 1, 2025 through December 31, 2026) and a
 2 third year renewal rate cap, for 2027.
 3

Dental	Renewals				
	2020	2021	2022	2023	2024
The Guardian					
ASO Fee	0.0%	0.0%	-1.8%	0.0%	0.0%
Budget Rates	14.4%	7.2%	0.0%	0.0%	0.0%

Dental	Current	Renewal	Projected Renewals	
	2025	2026	2027	2028
MetLife				
Fully-insured Dental	8.2%*	0.0%**	5.5%**	5.5%**

* Implemented new dental program in 2025

** 2025 proposal included a two-year rate guarantee, plus a 8.0% renewal rate cap for 2027; Mercer is projecting a trend increase (5.5%)

4 See Attachment 3 for renewals.
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7 The following exhibit illustrates the projected plan year costs (per employee per month,
 8 or PEPM) from 2020 through 2025. These costs are compared to the data from Mercer’s
 9 Survey. In addition to plan costs, data from the Survey was used to benchmark dental
 10 plan designs, to ensure the plans being offered by Suburban Water Systems are
 11 competitive to “benchmarks” in the marketplace.
 12

Year	Dental PEPM		
	Guardian	California*	National*
2020	\$84	\$77	\$67
2021	\$89	\$85	\$69
2022	\$81	\$80	\$71
2023	\$80	\$79	\$73
2024	\$87	\$82	\$75
	MetLife		
2025	\$78		

* Mercer's National Survey of Employer-sponsored Health Plans

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 15 Q11. What is the breakdown of cost for the employer-sponsored dental insurance (employer
 16 vs. employee contributions)?

17 A11. Please see the table below.

Dental Cost Breakdown		
Year	Suburban Water	Employee
2020	65.8%	34.2%
2021	65.6%	34.4%
2022	54.5%	45.5%
2023	63.4%	36.6%
2024	66.1%	33.9%
2025	56.4%	43.6%

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3 Q12. Does this conclude your testimony?

4 A12. Yes it does.

ATTACHMENT 1



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, call 1-800-521-2227 or at <https://policy-srv.box.com/s/771i9hldp3k77boqhgbbq8q97171o9fnx>.

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 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$1,000 Individual / \$2,000 Family Out-of-Network: \$5,000 Individual / \$10,000 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. Services that charge a copayment, prescription drugs, certain preventive care 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 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?	In-Network: \$4,000 Individual / \$8,000 Family Out-of-Network: \$10,000 Individual / \$20,000 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?	Premiums, balance-billing charges, 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.bcbstx.com or call 1-800-810-2583 for a list of network 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 an out-of-network 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 network provider might use an out-of-network 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?	No.	You can see the specialist you choose without a referral.



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
		In-Network Provider (You will pay the least)	Out-of-Network 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	\$30 <u>copayment/visit</u> ; deductible does not apply	50% <u>coinsurance</u> after deductible	Virtual visits are available, please refer to your plan policy for more details.
	<u>Specialist</u> visit	\$30 <u>copayment/visit</u> ; deductible does not apply	50% <u>coinsurance</u> after deductible	None
	Preventive care/ <u>screening/immunization</u>	No Charge; deductible does not apply	50% <u>coinsurance</u> after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No Charge for child immunizations Out-of-Network through the 6th birthday.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None

*For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/7719h1dp3k77boqhgq8q97171o9fmx>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network 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.bcbstx.com	Generic drugs	\$5 retail/\$12.50 mail order copayment/prescription; deductible does not apply	\$5 copayment/prescription plus 50% coinsurance; deductible does not apply	Retail covers a 30-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply. Out-of-Network mail order is not covered. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. For Out-of-Network pharmacy, member must file claim.
	Preferred brand drugs	\$20 retail/\$50 mail order copayment/prescription; deductible does not apply	\$20 copayment/prescription plus 50% coinsurance; deductible does not apply	Certain drugs require approval before they will be covered. The cost-sharing for insulin included in the drug list will not exceed \$25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.
	Non-preferred brand drugs	\$50 retail/\$125 mail order copayment/prescription; deductible does not apply	\$50 copayment/prescription plus 50% coinsurance; deductible does not apply	For In-Network benefit, <u>specialty drugs</u> must be obtained from In-Network specialty pharmacy provider. <u>Specialty drugs</u> are limited to a 30-day supply except for certain FDA-designated dosing regimens. Mail order is not covered.
If you have outpatient surgery	<u>Specialty drugs</u>	20% coinsurance; \$250 max/prescription deductible does not apply	20% coinsurance; \$250 max/prescription plus 50% coinsurance; deductible does not apply	
	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need immediate medical attention	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	None
	<u>Emergency room care</u>	Facility Charges: \$250 copayment/visit plus 20% coinsurance after deductible ER Physician Charges: 20% coinsurance after deductible	Facility Charges: \$250 copayment/visit plus 20% coinsurance after deductible ER Physician Charges: 20% coinsurance after deductible	Emergency room <u>copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% coinsurance after deductible	20% coinsurance after deductible	Ground and air transportation covered.
	<u>Urgent care</u>	\$30 copayment/visit; deductible does not apply	50% coinsurance after deductible	You may have to pay for services that are not covered by the visit fee. For an example, see "if you have a test" on page 2.

*For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/7719h1dp3k77boqhgq8q97171o9fnx>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	Physician/surgeon fees	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copayment/office visit; deductible does not apply 20% <u>coinsurance</u> after deductible for other outpatient services	50% <u>coinsurance</u> after deductible	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your <u>plan</u> policy for more details.
	Inpatient services	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
If you are pregnant	Office visits	\$30 <u>copayment</u> /visit; deductible does not apply	50% <u>coinsurance</u> after deductible	<u>Copayment</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and service described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	
	Childbirth/delivery facility services	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None

*For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/77119hldp3k77boqhgq8q97171o9fmx>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% coinsurance after deductible	50% coinsurance after deductible	Limited to 60 visits per calendar year. Preauthorization is required.
	<u>Rehabilitation services</u>	\$30 copayment/office visit; deductible does not apply 20% coinsurance after deductible for other outpatient services	50% coinsurance after deductible	Limited to 35 visits combined for all therapies per calendar year. Includes, but is not limited to, occupational, physical, and manipulative therapy.
	<u>Habilitation services</u>	\$30 copayment/office visit; deductible does not apply 20% coinsurance after deductible for other outpatient services	50% coinsurance after deductible	Limited to 25 days per calendar year.
	<u>Skilled nursing care</u>	20% coinsurance after deductible	50% coinsurance after deductible	None
	<u>Durable medical equipment</u>	20% coinsurance after deductible	50% coinsurance after deductible	None
	<u>Hospice services</u>	20% coinsurance after deductible	50% coinsurance after deductible	None
If your child needs dental or eye care	Children's eye exam	\$30 copayment/visit; deductible does not apply	50% coinsurance after deductible	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)	
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care • Hearing aids (1 per ear per 36-month period) • Infertility treatment • Routine eye care (Adult)

*For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/7719hldp3k77boqhgq8q97171o9fnx>.

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 is: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

Does this plan provide Minimum Essential Coverage? Yes.

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Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,000
- Specialist copayment \$30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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 \$12,700

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,400

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,000
- Specialist copayment \$30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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 \$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,620

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,000
- Specialist copayment \$30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

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

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U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-637-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

To receive language or communication assistance free of charge, please call us at 855-710-6984.	
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo. تلقى المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinit's'á'góó, shá ata' hodooni ninízingo, t'áájí'k'eh bee náhaz'á. 1-866-560-4042 jí' hodíílini. برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلات کی مدد حاصل کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.



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, call 1-800-521-2227 or at <https://policy-srv.box.com/s/iqgze9f31r1w8wvgj318r83pk9k1ywh>.

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 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$1,650 Individual / \$3,300 Family Out-of-Network: \$5,000 Individual / \$10,000 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care is 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 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?	In-Network: \$3,300 Individual / \$6,600 Family Out-of-Network: \$10,000 Individual / \$20,000 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?	Premiums, balance-billing charges, 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.bcbstx.com or call 1-800-810-2583 for a list of network 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 an out-of-network 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 network provider might use an out-of-network 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?	No.	You can see the specialist you choose without a referral.



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
		In-Network Provider (You will pay the least)	Out-of-Network 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% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	50% <u>coinsurance</u> after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No Charge for child immunizations Out-of-Network through the 6th birthday.
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None

*For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/igge9t31r1w8wvgj318r83kpk9k1ywh>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network 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.bcbstx.com	Generic drugs	\$5 retail/\$12.50 mail order copayment/prescription after deductible	\$5 copayment/prescription plus 50% coinsurance after deductible	Retail covers a 30-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply. Out-of-Network mail order is not covered. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. For Out-of-Network pharmacy, member must file claim.
	Preferred brand drugs	\$20 retail/\$50 mail order copayment/prescription after deductible	\$20 copayment/prescription plus 50% coinsurance after deductible	Certain drugs require approval before they will be covered. The cost-sharing for insulin included in the drug list will not exceed \$25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.
	Non-preferred brand drugs	\$50 retail/\$125 mail order copayment/prescription after deductible	\$50 copayment/prescription plus 50% coinsurance after deductible	For In-Network benefit, <u>specialty drugs</u> must be obtained from In-Network specialty pharmacy provider. <u>Specialty drugs</u> are limited to a 30-day supply except for certain FDA-designated dosing regimens. Mail order is not covered.
If you have outpatient surgery	<u>Specialty drugs</u>	20% coinsurance; \$250 max/prescription after deductible	20% coinsurance; \$250 max/prescription plus 50% coinsurance after deductible	None
	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need immediate medical attention	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	None
	<u>Emergency room care</u>	Facility Charges: 20% coinsurance after deductible ER Physician Charges: 20% coinsurance after deductible	Facility Charges: 20% coinsurance after deductible ER Physician Charges: 20% coinsurance after deductible	None
	<u>Emergency medical transportation</u>	20% coinsurance after deductible	20% coinsurance after deductible	Ground and air transportation covered.
	<u>Urgent care</u>	20% coinsurance after deductible	50% coinsurance after deductible	You may have to pay for services that are not covered by the visit fee. For an example, see "if you have a test" on page 2.

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		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	Physician/surgeon fees	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your plan policy for more details.
	Inpatient services	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
If you are pregnant	Office visits	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	Cost sharing does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and service described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	Childbirth/delivery facility services	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	Home health care	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	Limited to 60 visits per calendar year. Preauthorization is required.
If you need help recovering or have other special health needs	Rehabilitation services	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	Limited to 35 visits combined for all therapies per calendar year. Includes, but is not limited to, occupational, physical, and manipulative therapy.
	Habilitation services	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	Limited to 25 days per calendar year.
	Skilled nursing care	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	Durable medical equipment	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	Hospice services	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	20% coinsurance after deductible	50% coinsurance after deductible	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Long-term care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
<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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
<ul style="list-style-type: none"> • Chiropractic care • Hearing aids (1 per ear per 36-month period) • Infertility treatment • Routine eye care (Adult)

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Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,650
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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 \$12,700

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,650
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,360

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,650
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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 \$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,650
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,270

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,650
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,650
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,860

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

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Office of Civil Rights Coordinator
300 E. Randolph St., 36th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-8965
Fax: 855-661-8960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-637-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

To receive language or communication assistance free of charge, please call us at 855-710-6984.	
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo. تلقى المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984.
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ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
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Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.



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, call 1-800-521-2227 or at <https://policy-srv.box.com/s/kw3cgnrsi404a995emlyy6outia2pkxr>.

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 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>In-Network: \$400 Individual / \$800 Family Out-of-Network: \$5,000 Individual / \$10,000 Family</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Services that charge a copayment, prescription drugs, certain preventive care are covered before you meet your deductible.</p>	<p>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 www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>In-Network: \$2,500 Individual / \$5,000 Family Out-of-Network: \$10,000 Individual / \$20,000 Family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of network providers.</p>	<p>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 an out-of-network 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 network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>

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
		In-Network Provider (You will pay the least)	Out-of-Network 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 copayment/visit; deductible does not apply	50% coinsurance after deductible	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	\$20 copayment/visit; deductible does not apply	50% coinsurance after deductible	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	50% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No Charge for child immunizations Out-of-Network through the 6th birthday.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% coinsurance after deductible	None

*For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/kw3cgnrsi404a995emlyy6outia2pkrs>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network 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.bcbstx.com	Generic drugs	\$5 retail/\$12.50 mail order copayment/prescription; deductible does not apply	\$5 copayment/prescription plus 50% coinsurance; deductible does not apply	Retail covers a 30-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply. Out-of-Network mail order is not covered. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. For Out-of-Network pharmacy, member must file claim.
	Preferred brand drugs	\$20 retail/\$50 mail order copayment/prescription; deductible does not apply	\$20 copayment/prescription plus 50% coinsurance; deductible does not apply	Certain drugs require approval before they will be covered. The cost-sharing for insulin included in the drug list will not exceed \$25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.
	Non-preferred brand drugs	\$50 retail/\$125 mail order copayment/prescription; deductible does not apply	\$50 copayment/prescription plus 50% coinsurance; deductible does not apply	For In-Network benefit, <u>specialty drugs</u> must be obtained from In-Network specialty pharmacy provider. <u>Specialty drugs</u> are limited to a 30-day supply except for certain FDA-designated dosing regimens. Mail order is not covered.
If you have outpatient surgery	<u>Specialty drugs</u>	20% coinsurance; \$250 max/prescription deductible does not apply	20% coinsurance; \$250 max/prescription plus 50% coinsurance; deductible does not apply	
	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need immediate medical attention	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	None
	<u>Emergency room care</u>	Facility Charges: \$150 copayment/visit plus 20% coinsurance after deductible ER Physician Charges: 20% coinsurance after deductible	Facility Charges: \$150 copayment/visit plus 20% coinsurance after deductible ER Physician Charges: 20% coinsurance after deductible	Emergency room copayment waived if admitted.
	<u>Emergency medical transportation</u>	20% coinsurance after deductible	20% coinsurance after deductible	Ground and air transportation covered.
	<u>Urgent care</u>	\$40 copayment/visit; deductible does not apply	50% coinsurance after deductible	You may have to pay for services that are not covered by the visit fee. For an example, see "if you have a test" on page 2.

*For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/kw3cgnrsi404a995emlyy6outia2pkrs>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	Physician/surgeon fees	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copayment/office visit</u> ; deductible does not apply 20% <u>coinsurance</u> after deductible for other outpatient services	50% <u>coinsurance</u> after deductible	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your plan policy for more details.
	Inpatient services	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
If you are pregnant	Office visits	\$20 <u>copayment/visit</u> ; deductible does not apply	50% <u>coinsurance</u> after deductible	<u>Copayment</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and service described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	Childbirth/delivery facility services	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	<u>Home health care</u>	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	Limited to 100 visits per calendar year. Preauthorization is required.
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	Limited to 35 visits combined for all therapies per calendar year. Includes, but is not limited to, occupational, physical, and manipulative therapy.
	<u>Habilitation services</u>	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	Limited to 100 visits per calendar year.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	<u>Hospice services</u>	20% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None

*For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/kw3cgnrsi404a995emlyy6outia2pkrs>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$20 <u>copayment/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u> after <u>deductible</u>	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Long-term care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care • Weight loss programs

*For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/kw3cgnrsi404a995emlyy6outia2pkrs>.

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 is: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

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 1-800-521-2227.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-521-2227.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-521-2227.

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 in-network pre-natal care and a hospital delivery)

- The plan's overall deductible **\$400**
- Specialist copayment **\$20**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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 **\$12,700**

In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,560

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$400**
- Specialist copayment **\$20**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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 **\$5,600**

In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible **\$400**
- Specialist copayment **\$20**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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**

In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000

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

Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 36th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-8965
Fax: 855-661-8960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-637-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

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हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
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Navajo	Niná: Doo bilagáana bizaad dinit's'á'góó, shá ata' hodooni ninízingo, t'áájí'k'eh bee náhaz'á. 1-866-560-4042 jí' hodíílini. برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلات کی مدد حاصل کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

Nexus Water Group

Network: PDP Plus

Coverage Type	Plan option 1 Gold Plan/Buy-up		Plan option 2 Silver Plan/Base	
	In-Network ¹ % of Negotiated Fee ²	Out-of-Network ¹ % of R&C Fee ^{**}	In-Network ¹ % of Negotiated Fee ²	Out-of-Network ¹ % of R&C Fee ^{**}
Type A: Preventive (cleanings, exams, X-rays)	100%	100%	100%	100%
Type B: Basic Restorative (fillings, extractions)	80%	80%	80%	80%
Type C: Major Restorative (bridges, dentures)	50%	50%	50%	50%
Type D: Orthodontia	50%	50%	50%	50%
Deductible[†]				
Individual	\$50	\$50	\$50	\$50
Family	\$150	\$150	\$150	\$150
Annual Maximum Benefit				
Per Person	\$2,500	\$2,500	\$1,500	\$1,500
Orthodontia Lifetime Maximum				
Per Person ^{***}	\$2,500	\$2,500	\$1,500	\$1,500

Child(ren)'s eligibility for dental coverage is from birth up to age 26.

¹ "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.

² Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

^{**} R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

[†] Applies only to Type B & C Services.

^{***} Available for adults and dependent children up to age 26.

List of Primary Covered Services & Limitations

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

Plan Type	Plan Option 1: Gold Plan/Buy-up How Many/How Often	Plan Option 2: Silver Plan/Base How Many/How Often
Type A — Preventive		
Prophylaxis (cleanings)	Two in 12 months	Two per calendar year
Oral Examinations	Two exams in 12 months	Two exams per calendar year
Topical Fluoride Applications	Two fluoride treatments per calendar year for dependent children up to his/her 19 th birthday	Two fluoride treatment per calendar year for dependent children up to his/her 19 th birthday

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

Nexus Water Group

X-rays	<ul style="list-style-type: none"> • Full mouth X-rays; one per 3 calendar years • Bitewings X-rays; one set in 12 months 	<ul style="list-style-type: none"> • Full mouth X-rays; one per 3 calendar years • Bitewing X-rays; one set in 12 months
Space Maintainers	Space maintainers for dependent children up to his/her 17 th birthday, once per tooth area per lifetime	Space maintainers for dependent children up to his/her 17 th birthday, once per tooth area per lifetime
Sealants	One application of sealant material every 36 months for each non-restored, non-decayed 1 st and 2 nd molar of a dependent child up to his/her 16 th birthday	One application of sealant material every 36 months for each non-restored, non-decayed 1 st and 2 nd molar of a dependent child up to his/her 16 th birthday
Type B — Basic Restorative		
Fillings	One replacement in 24 months	One replacement in 24 months
Simple Extractions		
Oral Surgery		
Endodontics	Root canal treatment limited to once per tooth per lifetime	Root canal treatment limited to once per tooth per lifetime
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontics	<ul style="list-style-type: none"> • Periodontal scaling and root planning once per quadrant, every 24 months • Periodontal surgery once per quadrant, every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year 	<ul style="list-style-type: none"> • Periodontal scaling and root planning once per quadrant, every 24 months • Periodontal surgery once per quadrant, every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year
Type C — Major Restorative		
Crown, Denture and Bridge Repair/ Recementations	Repairs: One in 24 months Recementations: One in 12 months	Repairs: One in 24 months Recementations: One in 12 months
Implants	Replacement once every 10 calendar years	Replacement once every 10 calendar years
Bridges and Dentures	<ul style="list-style-type: none"> • Initial placement to replace one or more natural teeth, which are lost while covered by the plan • Dentures and bridgework replacement; one every 10 calendar years • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed 	<ul style="list-style-type: none"> • Initial placement to replace one or more natural teeth, which are lost while covered by the plan • Dentures and bridgework replacement; one every 10 calendar years • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns, Inlays and Onlays	Replacement once every 10 calendar years	Replacement once every 10 calendar years
Type D — Orthodontia		

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

Nexus Water Group

- You, your spouse and your children, up to age 26, are covered while Dental insurance is in effect
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia
- Payments are on a repetitive basis
- 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary
- Orthodontic benefits end at cancellation of coverage

- You, your spouse and your children, up to age 26, are covered while Dental insurance is in effect
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia
- Payments are on a repetitive basis
- 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary
- Orthodontic benefits end at cancellation of coverage

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category, but is not a complete description of the plan.

Exclusions

This plan does not cover the following services, treatments and supplies:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
 - Scaling and polishing of teeth; or
 - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
 - Covered under any workers' compensation or occupational disease law;
 - Covered under any employer liability law;
 - For which the employer of the person receiving such services is not required to pay; or
 - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;



Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

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- The following when charged by the Dentist on a separate basis:
 - Claim form completion;
 - Infection control such as gloves, masks, and sterilization of supplies; or
 - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Initial installation of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders;
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images.

Limitations

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, payment is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's payment for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP15-2T) issued by Metropolitan Life Insurance Company (MetLife). Coverage terminates when your participation ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166.

Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Ask your MetLife group representative for costs and complete details.

Questions & Answers

Q. Who is a participating dentist?



Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

Nexus Water Group

- A.** A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 30% – 45% below the average fees charged in a dentist's community for the same or substantially similar services.†
- Q. How do I find a participating dentist?**
- A.** There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.
- Q. What services are covered under this plan?**
- A.** The Plan documents set forth the services covered by your plan. The List of Primary Covered Services & Limitations herein contains a summary of covered services. In the event of a conflict between the Plan documents and this summary, the terms of the Plan documents shall govern.
- Q. May I choose a non-participating dentist?**
- A.** Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist your out-of-pocket costs may be higher.
- Q. Can my dentist apply for participation in the network?**
- A.** Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.†† The website and phone number are for use by dental professionals only.
- Q. How are claims processed?**
- A.** Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-942-0854.
- Q. Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?**
- A.** Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of \$300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.
- Q. Can MetLife help me find a dentist outside of the U.S. if I am traveling?**
- A.** Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.
- Q. How does MetLife coordinate benefits with other insurance plans?**
- A.** Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.
- Q. Do I need an ID card?**
- A.** No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

†Based on internal analysis by MetLife. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

††Due to contractual requirements, MetLife is prevented from soliciting certain providers.

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

Nexus Water Group

*AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations. Exclusions: The AXA Travel Assistance Program is available for participants in traveling status. Whenever a trip exceeds 120 days, the participant is no longer considered to be in traveling status and is therefore no longer eligible for the services. Also, AXA Assistance USA will not evacuate or repatriate participants without medical authorization; with mild lesions, simple injuries such as sprains, simple fractures or mild sickness which can be treated by local doctors and do not prevent the member from continuing his/her trip or returning home; or with infections under treatment and not yet healed. Benefits will not be paid for any loss or injury that is caused by or is the result from: pregnancy and childbirth except for complications of pregnancy, and mental and nervous disorders unless hospitalized. Reimbursements for non-medical services such as hotel, restaurant, taxi expenses or baggage loss while traveling are not covered. The maximum benefit per person for costs associated with evacuations, repatriations or the return of mortal remains is US\$500,000. Treatment must be authorized and arranged by AXA Assistance's designated personnel to be eligible for benefits under this program. All services must be provided and arranged by AXA Assistance USA, Inc. No claims for reimbursement will be accepted.

**Refer to your dental benefits plan summary for your out-of-network dental coverage.

Group dental plans featuring the Preferred Dentist Program are provided by Metropolitan Life Insurance Company, New York, NY.



Dental insurance

Taking care of your teeth is about more than just covering cavities and cleanings. It also means accounting for more expensive dental work, and your overall health.

With dental insurance, routine preventive care can lead to better overall health. And you'll be able to save money if any extensive dental work is required.

Who is it for?

Everyone should have access to great dental coverage, which is why we offer comprehensive plans that are available through employers as part of your benefit offerings.

What does it cover?

Dental insurance helps to protect your overall oral care. That includes services like preventive cleanings, x-rays, restorative services like fillings, and other more serious forms of oral surgery if you ever need them.

Why should I consider it?

Poor oral health isn't just aesthetic, it's also been linked to conditions including diabetes, heart disease, and strokes. So, while brushing and flossing every day can help keep your teeth clean, nothing should replace regular visits to the dentist.



Staying healthy

Joe visits his dentist for a routine dental cleaning, to take care of his teeth as well as his overall health.

Oral health is about more than just teeth and gums. It's also essential for a range of other health and wellbeing reasons:

Cardiovascular disease: Some research suggests that heart disease, clogged arteries, and infections may be linked to inflammation and infections from oral bacteria.

Osteoporosis: Weak and brittle bones may be linked to tooth loss.

Diabetes: Research shows that people with gum disease find it more difficult to control their blood sugar levels.

Alzheimer's disease: Tooth loss before the age of 35 may be a risk factor for Alzheimer's disease.

All information contained here is from the Mayo Clinic, Oral Health: A Window to Your Overall Health, www.mayoclinic.com. 2018.

You will receive these benefits if you meet the conditions listed in the policy.



Your dental coverage

Option 1 or 2: High Plan or Low Plan plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	Option 1: High Plan		Option 2: Low Plan	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Calendar year deductible	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$50	\$50	\$50	\$50
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care	100%	100%	100%	100%
Basic Care	80%	80%	80%	80%
Major Care	50%	50%	50%	50%
Orthodontia	50%	50%	50%	50%
Annual Maximum Benefit	\$2500	\$2500	\$1000	\$1000
Lifetime Orthodontia Maximum	\$1000		\$1000	
Dependent Age Limits	23		23	



Your dental coverage

A Sample of Services Covered by Your Plan:

		Option 1: High Plan		Option 2: Low Plan	
		<i>Plan pays (on average)</i>		<i>Plan pays (on average)</i>	
		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	2 per calendar year		2 per calendar year	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	Under Age 19		Under Age 19	
	Oral Exams	100%	100%	100%	100%
	Periodontal Maintenance	100%	100%	100%	100%
	Frequency:	2 per calendar year		2 per calendar year	
	X-rays	100%	100%	100%	100%
Basic Care	Anesthesia*	80%	80%	80%	80%
	Fillings‡	80%	80%	80%	80%
	Perio Surgery	80%	80%	80%	80%
	Repair & Maintenance of Crowns, Bridges & Dentures	80%	80%	80%	80%
	Root Canal	80%	80%	80%	80%
	Scaling & Root Planing (per quadrant)	80%	80%	80%	80%
	Simple Extractions	80%	80%	80%	80%
	Single Crowns	80%	80%	50%	50%
Major Care	Surgical Extractions	80%	80%	80%	80%
	Bridges and Dentures	50%	50%	50%	50%
	Dental Implants	50%	50%	50%	50%
Orthodontia	Inlays, Onlays, Veneers**	50%	50%	50%	50%
	Orthodontia	50%	50%	50%	50%
	Limits:	Child(ren)		Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filling material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.



Your dental coverage

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..

Find A Dentist:

Visit www.GuardianAnytime.com Click on “Find A Provider”; You will need to know your plan, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian’s DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-I-DG2000 et al.
- **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

DentalGuard Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides DENTAL insurance only. Policy Form # GP-1-DG2000, et al, GP-1-DEN-16



Dental insurance

Taking care of your teeth is about more than just covering cavities and cleanings. It also means accounting for more expensive dental work, and your overall health.

With dental insurance, routine preventive care can lead to better overall health. And you'll be able to save money if any extensive dental work is required.

Who is it for?

Everyone should have access to great dental coverage, which is why we offer comprehensive plans that are available through employers as part of your benefit offerings.

What does it cover?

Dental insurance helps to protect your overall oral care. That includes services like preventive cleanings, x-rays, restorative services like fillings, and other more serious forms of oral surgery if you ever need them.

Why should I consider it?

Poor oral health isn't just aesthetic, it's also been linked to conditions including diabetes, heart disease, and strokes. So, while brushing and flossing every day can help keep your teeth clean, nothing should replace regular visits to the dentist.



Staying healthy

Joe visits his dentist for a routine dental cleaning, to take care of his teeth as well as his overall health.

Oral health is about more than just teeth and gums. It's also essential for a range of other health and wellbeing reasons:

Cardiovascular disease: Some research suggests that heart disease, clogged arteries, and infections may be linked to inflammation and infections from oral bacteria.

Osteoporosis: Weak and brittle bones may be linked to tooth loss.

Diabetes: Research shows that people with gum disease find it more difficult to control their blood sugar levels.

Alzheimer's disease: Tooth loss before the age of 35 may be a risk factor for Alzheimer's disease.

All information contained here is from the Mayo Clinic, Oral Health: A Window to Your Overall Health, www.mayoclinic.com. 2018.

You will receive these benefits if you meet the conditions listed in the policy.



Your dental coverage

Option 1 or 2: High Plan or Low Plan plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	Option 1: High Plan		Option 2: Low Plan	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Calendar year deductible	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$50	\$50	\$50	\$50
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care	100%	100%	100%	100%
Basic Care	80%	80%	80%	80%
Major Care	50%	50%	50%	50%
Orthodontia	50%	50%	50%	50%
Annual Maximum Benefit	\$2500	\$2500	\$1000	\$1000
Lifetime Orthodontia Maximum	\$1000		\$1000	
Dependent Age Limits	23		23	



Your dental coverage

A Sample of Services Covered by Your Plan:

		Option 1: High Plan		Option 2: Low Plan	
		<i>Plan pays (on average)</i>		<i>Plan pays (on average)</i>	
		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	2 per calendar year		2 per calendar year	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	Under Age 19		Under Age 19	
	Oral Exams	100%	100%	100%	100%
	Periodontal Maintenance	100%	100%	100%	100%
	Frequency:	2 per calendar year		2 per calendar year	
	X-rays	100%	100%	100%	100%
Basic Care	Anesthesia*	80%	80%	80%	80%
	Fillings‡	80%	80%	80%	80%
	Perio Surgery	80%	80%	80%	80%
	Repair & Maintenance of Crowns, Bridges & Dentures	80%	80%	80%	80%
	Root Canal	80%	80%	80%	80%
	Scaling & Root Planing (per quadrant)	80%	80%	80%	80%
	Simple Extractions	80%	80%	80%	80%
	Single Crowns	80%	80%	50%	50%
Major Care	Surgical Extractions	80%	80%	80%	80%
	Bridges and Dentures	50%	50%	50%	50%
	Dental Implants	50%	50%	50%	50%
Orthodontia	Inlays, Onlays, Veneers**	50%	50%	50%	50%
	Orthodontia	50%	50%	50%	50%
	Limits:	Child(ren)		Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filling material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.



Your dental coverage

Manage Your Benefits:

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Find A Dentist:

Visit www.GuardianAnytime.com Click on “Find A Provider”; You will need to know your plan, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian’s DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-I-DG2000 et al.
- **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

DentalGuard Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides DENTAL insurance only. Policy Form # GP-1-DG2000, et al, GP-1-DEN-16



Dental insurance

Taking care of your teeth is about more than just covering cavities and cleanings. It also means accounting for more expensive dental work, and your overall health.

With dental insurance, routine preventive care can lead to better overall health. And you'll be able to save money if any extensive dental work is required.

Who is it for?

Everyone should have access to great dental coverage, which is why we offer comprehensive plans that are available through employers as part of your benefit offerings.

What does it cover?

Dental insurance helps to protect your overall oral care. That includes services like preventive cleanings, x-rays, restorative services like fillings, and other more serious forms of oral surgery if you ever need them.

Why should I consider it?

Poor oral health isn't just aesthetic, it's also been linked to conditions including diabetes, heart disease, and strokes. So, while brushing and flossing every day can help keep your teeth clean, nothing should replace regular visits to the dentist.



Staying healthy

Joe visits his dentist for a routine dental cleaning, to take care of his teeth as well as his overall health.

Oral health is about more than just teeth and gums. It's also essential for a range of other health and wellbeing reasons:

Cardiovascular disease: Some research suggests that heart disease, clogged arteries, and infections may be linked to inflammation and infections from oral bacteria.

Osteoporosis: Weak and brittle bones may be linked to tooth loss.

Diabetes: Research shows that people with gum disease find it more difficult to control their blood sugar levels.

Alzheimer's disease: Tooth loss before the age of 35 may be a risk factor for Alzheimer's disease.

All information contained here is from the Mayo Clinic, Oral Health: A Window to Your Overall Health, www.mayoclinic.com. 2018.

You will receive these benefits if you meet the conditions listed in the policy.



Your dental coverage

Option 1 or 2: High Plan or Low Plan plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	Option 1: High Plan		Option 2: Low Plan	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Calendar year deductible	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$50	\$50	\$50	\$50
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care	100%	100%	100%	100%
Basic Care	80%	80%	80%	80%
Major Care	50%	50%	50%	50%
Orthodontia	50%	50%	50%	50%
Annual Maximum Benefit	\$2500	\$2500	\$1000	\$1000
Lifetime Orthodontia Maximum	\$1000		\$1000	
Dependent Age Limits	23		23	



Your dental coverage

A Sample of Services Covered by Your Plan:

		Option 1: High Plan		Option 2: Low Plan	
		<i>Plan pays (on average)</i>		<i>Plan pays (on average)</i>	
		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	2 per calendar year		2 per calendar year	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	Under Age 19		Under Age 19	
	Oral Exams	100%	100%	100%	100%
	Periodontal Maintenance	100%	100%	100%	100%
	Frequency:	2 per calendar year		2 per calendar year	
	X-rays	100%	100%	100%	100%
Basic Care	Anesthesia*	80%	80%	80%	80%
	Fillings‡	80%	80%	80%	80%
	Perio Surgery	80%	80%	80%	80%
	Repair & Maintenance of Crowns, Bridges & Dentures	80%	80%	80%	80%
	Root Canal	80%	80%	80%	80%
	Scaling & Root Planing (per quadrant)	80%	80%	80%	80%
	Simple Extractions	80%	80%	80%	80%
	Single Crowns	80%	80%	50%	50%
Major Care	Surgical Extractions	80%	80%	80%	80%
	Bridges and Dentures	50%	50%	50%	50%
	Dental Implants	50%	50%	50%	50%
Orthodontia	Inlays, Onlays, Veneers**	50%	50%	50%	50%
	Orthodontia	50%	50%	50%	50%
	Limits:	Child(ren)		Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filling material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.



Your dental coverage

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..

Find A Dentist:

Visit www.GuardianAnytime.com Click on “Find A Provider”; You will need to know your plan, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian’s DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-I-DG2000 et al.
- **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

DentalGuard Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides DENTAL insurance only. Policy Form # GP-1-DG2000, et al, GP-1-DEN-16



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, call 1-866-633-2446 or visit welcometouhc.com. 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 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>Network: \$1,000 Individual / \$2,000 Family Out-of-Network: \$5,000 Individual / \$10,000 Family Per calendar year.</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care and categories with a copay are covered before you meet your deductible.</p>	<p>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 www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Network: \$4,000 Individual / \$8,000 Family Out-of-Network: \$10,000 Individual / \$20,000 Family Per calendar year.</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See myuhc.com or call 1-866-633-2446 for a list of network providers.</p>	<p>You pay the least if you use a provider in the Designated Network. You pay more if you use a provider in the Network. You will pay the most if you use an out-of-network 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 network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>



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
		Network Provider (You will pay the least)	Out-of-Network 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	\$30 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	Virtual visits - No Charge by a Designated Virtual Network Provider. No virtual coverage out-of-network If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Specialist</u> visit	\$50 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Preventive</u> care/ <u>screening</u> / <u>immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. No coverage <u>out-of-network</u>
	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	Lab Testing: Not Covered X-Ray/Diagnostic: 50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or a \$1,000 penalty applies. No coverage <u>out-of-network</u> for lab testing
If you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or a \$1,000 penalty applies.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: \$5 <u>copay, deductible</u> does not apply. Mail-Order: \$10 <u>copay, deductible</u> does not apply.	Retail: \$5 <u>copay, deductible</u> does not apply.	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. If you use an <u>out-of-network pharmacy</u> (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 – Your Mid-Range Cost Option	Retail: \$20 <u>copay, deductible</u> does not apply. Mail-Order: \$40 <u>copay, deductible</u> does not apply.	Retail: \$20 <u>copay, deductible</u> does not apply.	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$50 <u>copay, deductible</u> does not apply. Mail-Order: \$100 <u>copay, deductible</u> does not apply.	Retail: \$50 <u>copay, deductible</u> does not apply.	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or a \$1,000 penalty applies. Out-of-network allowed amounts for Facility Fees are limited to \$760 per date of service
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay per visit, deductible</u> does not apply.	\$250 <u>copay per visit, deductible</u> does not apply.	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	*20% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<u>Urgent care</u>	\$50 <u>copay per visit, deductible</u> does not apply.	50% <u>coinsurance</u>	Virtual visits - No Charge by a Designated Virtual Network Provider. No virtual coverage out-of-network If you receive services in addition to <u>Urgent care visit</u> , additional <u>copays, deductibles, or coinsurance</u> may apply e.g. surgery.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need		What You Will Pay		Limitations, Exceptions, & Other Important Information
	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization is required <u>out-of-network</u> or no coverage.	
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	<u>Network</u> Partial hospitalization/intensive outpatient treatment: 20% <u>coinsurance</u> . Preauthorization is required <u>out-of-network</u> for certain services or no coverage. See your policy or <u>plan</u> document for additional information about EAP benefits.	
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization is required <u>out-of-network</u> or no coverage. See your policy or <u>plan</u> document for additional information about EAP benefits.	
If you are pregnant	Office visits	No Charge	50% <u>coinsurance</u>	Cost sharing does not apply for preventive services. Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)	
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>		
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Inpatient preauthorization applies <u>out-of-network</u> if stay exceeds 48 hours (C-Section: 96 hours) or no coverage.	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 100 visits per calendar year. Out-of-network allowed amounts for Home health care are limited to \$150 per visit. Preauthorization is required <u>out-of-network</u> or a \$1,000 penalty applies.	
	Rehabilitation services	\$30 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	Outpatient rehabilitation services are unlimited per calendar year. No limits apply for treatment of Autism Spectrum Disorder Services. No coverage <u>out-of-network</u> for physical and occupational therapy.	

* For more information about limitations and exceptions, see the plan or policy document at welcometouch.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Habilitative services</u>	\$30 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	Services are provided under <u>Rehabilitation Services</u> above. No limits apply for treatment of Autism Spectrum Disorder Services. No coverage <u>out-of-network</u> for physical and occupational therapy.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 100 days per calendar year. <u>Preauthorization</u> is required <u>out-of-network</u> or a \$1,000 penalty applies.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	No coverage <u>out-of-network</u> for durable medical equipment
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility or a \$1,000 penalty applies.
If your child needs dental or eye care	Children's eye exam	\$30 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Limited to 1 exam every 24 months. No coverage <u>out-of-network</u> .
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

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.)	
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care • Glasses 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when travelling outside - the U.S.
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none"> • Acupuncture – 20 visits per calendar year • Bariatric surgery 	<ul style="list-style-type: none"> • Private duty nursing • Routine foot care – Except as covered for Diabetes
<ul style="list-style-type: none"> • Acupuncture – 20 visits per calendar year • Bariatric surgery 	<ul style="list-style-type: none"> • Routine eye care (adult) - 1 exam per 24 months • Weight loss programs – Real Appeal

* For more information about limitations and exceptions, see the plan or policy document at welcometouhnc.com.

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 is: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhcc.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: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or 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.dmhcc.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 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinekehgo shika a'ohwol ninisingo, kwijigo holne' 1-866-633-2446.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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 in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,000
- Specialist copay \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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)

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)

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,000
- Specialist copay \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,000
- Specialist copay \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60

The total Peg would pay is \$2,870

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$150
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Joe would pay is \$850

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is \$1,430

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意： 如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LUU Y: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đãi thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال برقم الهاتف المجاني المدرج داخل مخلص المزاي والتغطية هذا. (Summary of Benefits and Coverage, SBC)

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage, SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខកតចេញថ្លៃ ដែលមានកន្លែងសេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការបំពេញ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saitaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyanam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍI BAA'ÁKONÍZIN: Diné (Navajo) bizaad bee yáni'ti'go, saad bee áka'anída'awo'ígíí, t'áá jík'eh, bee ná'ahóót'i'. T'áá shóodí Naaltsoos Bee 'Aa'áhayání dóo Bee 'Ak'é'asti' Bee Baa Hane'i (Summary of Benefits and Coverage, SBC) biyi' t'áá jík'ehgo béesh bee hane'i bika'ígíí bee hodílnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).



English

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in your language, first call your insurance company's phone number at 1-800-842-2656. Someone who speaks your language can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

Español

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su compañía de seguros. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su compañía de seguros al 1-800-842-2656.

Alguien que habla español puede ayudarlo. Si necesita ayuda adicional, llame a la línea directa del Departamento de seguros al 1-800-927-4357. (Spanish)

中文

重要事項: 您與您的醫生或醫療保險公司交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請先致電您的保險公司，電話號碼 1-800-842-2656
說中文人士將為您提供協助。如需更多協助，請致電保險部熱線 1-800-927-4357 (Chinese)

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

注意事項：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर दिए टोल-फ्री फोन नंबर पर काल करें।


CEEBOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (Khmer-Cambodian) សូមទូរស័ព្ទទៅលេខកំរិតតម្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

Ընդհանուր թեթև հայերեն (Armenian) եք խոսում, անվճար լեզվական օգնության ծառայություններ են հասանելի Ձեզ: Խոսողովու՜մ է՝ զանգահարե՛լ անվճար հեռախոսահամարով, որը նշվել է Ձեր ճանաչողական քարտի վրա:

Select Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Select Plus
 <p>Network coverage only You can usually save money when you receive care for covered health care services from network providers.</p>	<input type="checkbox"/>
 <p>Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.</p>	<input checked="" type="checkbox"/>
 <p>Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.</p>	<input type="checkbox"/>
 <p>Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.</p>	<input type="checkbox"/>
 <p>Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.</p>	<input checked="" type="checkbox"/>
 <p>Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.</p>	<input checked="" type="checkbox"/>
 <p>Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.</p>	<input type="checkbox"/>
 <p>Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.</p>	<input type="checkbox"/>
 <p>Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.</p>	<input type="checkbox"/>

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Select Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	\$1,000	\$5,000
Family	\$2,000	\$10,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

	In Network	Out-of-Network
Annual Out-of-Pocket Limit		
Individual	\$4,000	\$10,000
Family	\$8,000	\$20,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

The below references to Certificate of Coverage (COC) is the same as Evidence of Coverage (EOC) throughout this Benefit Summary.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care		No copay	Not covered
<p>Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.</p> <p>Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.</p>			
Office Services - Sickness & Injury			
Primary Care Physician		\$30 copay	50%*
<p>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.</p>			
Specialist		\$50 copay	50%*
<p>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.</p>			
Urgent Care		\$50 copay	50%*
<p>Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.</p>			

*After the Annual Medical Deductible has been met.

†Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Designated Network	Network	Out-of-Network
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Virtual Care Services

No copay

Not covered

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.

Vision Exams

\$30 copay

Not covered

Limited to 1 exam every 24 months.

Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.

Emergency Care

Emergency Ambulance

20%*

20%*

Non-Emergency Ambulance¹

20%*

50%*

Accidental Dental and Oral Surgery

20%*

20%*

Emergency Room

\$250 copay

\$250 copay

Inpatient Care

Congenital Heart Disease Surgeries¹

20%*

50%*

Hospital Inpatient Stays¹

20%*

50%*

Inpatient Habilitative Services¹

The amount you pay is based on where the covered health care service is provided.

Skilled Nursing Facility & Inpatient Rehabilitation Facility Services¹

20%*

50%*

Limited to 100 days per year in a Skilled Nursing Facility.

Outpatient Care

Habilitative Services and Manipulative Treatment

\$30 copay

50%*

Limited to 24 visits of manipulative treatments per year.

Limits will be the same as, and combined with those stated under Rehabilitation Services.

Out-of-Network Benefits are not available for physical therapy, occupational therapy, and Manipulative Treatments.

Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Designated Network	Network	Out-of-Network
Home Health Care ¹		20%*	50%*
<i>Limited to 100 visits per year.</i>			
<i>For Out-of-Network benefits, Allowed Amounts are limited to \$150 per visit.</i>			
<i>One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.</i>			
Lab Testing ¹	No copay	No copay	Not covered
Major Diagnostic and Imaging ¹		20%*	50%*
Physician Fees for Surgical and Medical Services		20%*	50%*
Rehabilitation Services		\$30 copay	50%*
<i>Limited to 24 visits of manipulative treatments per year.</i>			
<i>Out-of-Network Benefits are not available for physical therapy, occupational therapy, and Manipulative Treatments.</i>			
<i>Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.</i>			
<i>Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.</i>			
Scopic Procedures		20%*	50%*
<i>Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.</i>			
Surgery ¹		20%*	50%*
<i>For Out-of-Network Benefits, Allowed Amount for Facility Fees are limited to \$760 per date of service.</i>			
Therapeutic Treatments ¹		20%*	50%*
<i>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.</i>			
<i>Out-of-Network Benefits are not available for dialysis services.</i>			
X-ray and other Diagnostic Testing ¹		No copay	50%*
Supplies and Services			
Diabetes Self-Management and Training ¹		The amount you pay is based on where the covered health care service is provided.	
<i>For Self-Management and Training, cost sharing will not exceed the costs for Physician office visit.</i>			
Durable Medical Equipment, Orthotics and Supplies		20%*	Not covered
Enteral Nutrition		20%*	50%*

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Designated Network	Network	Out-of-Network
Hearing Aids		20%*	50%*
<i>Limited to \$2,500 every year.</i>			
<i>Benefits are further limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.</i>			
Ostomy Supplies		20%*	Not covered
Pharmaceutical Products		20%*	50%*
<i>Administered on an outpatient basis in a Hospital, Alternate Facility or doctor's office.</i>			
Prosthetic Devices ¹		20%*	50%*
<i>Limited to a single purchase of each type of prosthetic device every three years.</i>			
<i>Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.</i>			
Urinary Catheters		20%*	Not covered
Pregnancy			
Maternity Services ¹		The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.
<i>We pay for Covered Health Care Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is no cost share for this Benefit.</i>			
<i>Benefits for office visits for prenatal care received from a Network provider are covered without cost sharing during the entire course of your pregnancy.</i>			
<i>All maternity items and services that are recommended preventive care and are required to be covered under the Affordable Care act, will be provided without cost share. Please refer to Preventive Care Services.</i>			
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient ¹		20%*	50%*
Outpatient ¹		\$30 copay	50%*
Partial Hospitalization ¹		20%*	50%*

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Other Services			
Acupuncture Treatment		\$30 copay	Not covered
<i>In Network: Limited to 20 treatments per year.</i>			
Cellular or Gene Therapy		The amount you pay is based on where the covered health care service is provided.	Not covered
<i>For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.</i>			
Clinical Trials ¹		The amount you pay is based on where the covered health care service is provided.	
Dental Anesthesia Services		20%*	50%*
<i>Limited to Covered Persons who are one of the following: a child under seven years of age; a person who is developmentally disabled regardless of age; a person whose health is compromised and for whom general anesthesia is required, regardless of age.</i>			
Diabetes Treatment		The amount you pay is based on where the covered health care service is provided. See prescription drug benefit and Durable Medical Equipment (DME), Orthotics and Supplies for coverage of diabetes equipment and supplies.	
<i>Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.</i>			
Fertility Preservation for Iatrogenic Infertility ¹		20%*	50%*
<i>Limited to \$20,000 per Covered Person per lifetime.</i>			
<i>Limited to \$5,000 for Prescription Drug Products per Covered Person.</i>			
<i>This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Agreement.</i>			
Gender Dysphoria		The amount you pay is based on where the covered health care service is provided.	
Hospice Care ¹		20%*	50%*
Mastectomy Services ¹		The amount you pay is based on where the covered health care service is provided.	
Obesity - Weight Loss Surgery ¹	The amount you pay is based on where the covered health care service is provided.		Not covered
<i>For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.</i>			
Off-Label Drug Use and Experimental or Investigational Services		The amount you pay is based on where the covered health care service is provided.	
Osteoporosis Services		The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Designated Network	Network	Out-of-Network
Preimplantation Genetic Testing (PGT) and Related Services ¹		20%*	50%*
<p><i>Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.</i></p> <p><i>Benefits for related services are limited to one Assisted Reproductive Technology (ART) procedure during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include the Preimplantation Genetic Testing (PGT) for the specific genetic disorder.</i></p>			
Reconstructive Procedures ¹		The amount you pay is based on where the covered health care service is provided.	
Telehealth Services		The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint (TMJ) Services ¹		The amount you pay is based on where the covered health care service is provided.	
Transplantation Services ¹		The amount you pay is based on where the covered health care service is provided.	Not covered
<p><i>Network Benefits must be received from a Designated Provider.</i></p>			

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Access

In Network and Out of Network

Annual Pharmacy Deductible	
Individual	You do not have to pay a pharmacy deductible
Family	You do not have to pay a pharmacy deductible

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail Network	Out-of-Network Pharmacy	Mail Order Network Pharmacy**
Tier 1 \$	\$5	\$5	\$10
Tier 2 \$\$	\$20	\$20	\$40
Tier 3 \$\$\$	\$50	\$50	\$100

* After the Annual Medical Deductible has been met.

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com[®] or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com[®] or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

Here's an example of how the plan's costs come into play.

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, \$15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.



Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to [welcometouhc.com](https://www.welcometouhc.com) > **Benefits** > **Find a Doctor or Facility**.
- Choose **Search for a health plan**.
- Choose **Select Plus** to view providers in the health plan's network.



Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to [welcometouhc.com](https://www.welcometouhc.com) > **Benefits** > **Pharmacy Benefits**.
- Select **Access** to view the medications that are covered under your plan.



Access your plan online.

With [myuhc.com](https://www.myuhc.com)®, you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.



Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.



Other important information about your benefits.

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Private-Duty Nursing
- Weight Loss Programs
- Long-Term Care
- Cosmetic Surgery
- Non-emergency care when traveling outside the U.S.
- Infertility Treatment
- Glasses
- Routine Foot Care
- Dental Care (Adult/Child)

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

Certain Preventative Care Medications may be covered at zero costshare. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

- Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the Certificate.
- Any product prescription or non-prescription for which the primary use is a source of dietary or nutritional products, nutritional supplements, or dietary management of disease, including vitamins (except prenatal) minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicines and prescription medical food products even when used for the treatment of a health condition, except as described under Phenylketonuria (PKU) Treatment in the Evidence of Coverage, except as required by dietary or dietary or state mandate. Phenylketonuria (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Network Physician provided that the diet is Medically Necessary. This exclusion does not apply to authorized Medically Necessary services to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).
- Drugs available over-the-counter. This exclusion does not apply to prescribed over-the-counter FDA-approved contraceptives or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a provider for which Benefits are available, without cost sharing, as described under Section 5 of the Combined Evidence of Coverage and Disclosure Form.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental or Investigational or Unproven Services and medications.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- Certain Prescription Drug Products for tobacco cessation.
- Certain compounded drugs.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Growth hormone therapy unless required by state law.
- Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.
- Prescription Drug Products when prescribed as sleep aids.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.

UnitedHealthcare does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at:
<http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us such as letters in others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (**Vietnamese**), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어 (**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (**Tagalog**), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русский (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تويوغللا تدهاسمل تامدخ ناف، (Arabic)، تيبرعل اشدحت تنك اذا: هيمنت
ىل ع جردملا يئاجملا فتاهل مقرب لاصتال اىجرى. لئل عحاتم تيئاجملا
كئب قصابلا فيرعتلا قاطب

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (**French**), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (**Polish**), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (**Portuguese**), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (**Italian**), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (**German**) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते हैं, आपको भाषा सहायता सेवाएं, नःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर काल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (**Hmong**), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά (**Greek**), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

PAKDAAR: Nu saritaem ti Ilocano (**Ilocano**), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍI BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yánilti`go, saad bee áka`anída`awo`ígíí, t`áá jíík`ch, bec ná`ahóót`i. T`áá shqoqí ninaaltsoos nitl`izi bee nééhozinígíí bine`dęé` t`áá jíík`chgo béesh bee hane`i biká`ígíí bee hodílnih.

OGOW: Haddii aad ku hadasho Soomaali (**Somali**), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

ગુજરાતી (Gujarati): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપ્ય છ. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિપર આપેલા સેભ્ય માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.



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, call 1-866-633-2446 or visit welcometouhc.com. 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 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>Network: \$500 Individual / \$1,000 Family Out-of-Network: \$5,000 Individual / \$10,000 Family Per calendar year.</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care and categories with a copay are covered before you meet your deductible.</p>	<p>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 www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Network: \$2,500 Individual / \$5,000 Family Out-of-Network: \$10,000 Individual / \$20,000 Family Per calendar year.</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See myuhc.com or call 1-866-633-2446 for a list of network providers.</p>	<p>You pay the least if you use a provider in the Designated Network. You pay more if you use a provider in the Network. You will pay the most if you use an out-of-network 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 network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>



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
		Network Provider (You will pay the least)	Out-of-Network 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 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	Virtual visits - No Charge by a Designated Virtual Network Provider. No virtual coverage <u>out-of-network</u> if you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Specialist</u> visit	\$40 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Preventive</u> care/ <u>screening</u> /immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. No coverage <u>out-of-network</u>
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	Lab Testing: Not Covered X-Ray/Diagnostic: 50% <u>coinsurance</u>	Preauthorization is required <u>out-of-network</u> for certain services or a \$1,000 penalty applies. No coverage <u>out-of-network</u> for lab testing
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization is required <u>out-of-network</u> or a \$1,000 penalty applies.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: \$5 <u>copay, deductible</u> does not apply. Mail-Order: \$10 <u>copay, deductible</u> does not apply.	Retail: \$5 <u>copay, deductible</u> does not apply.	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. If you use an <u>out-of-network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 – Your Mid-Range Cost Option	Retail: \$20 <u>copay, deductible</u> does not apply. Mail-Order: \$40 <u>copay, deductible</u> does not apply.	Retail: \$20 <u>copay, deductible</u> does not apply.	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$50 <u>copay, deductible</u> does not apply. Mail-Order: \$100 <u>copay, deductible</u> does not apply.	Retail: \$50 <u>copay, deductible</u> does not apply.	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization is required <u>out-of-network</u> for certain services or a \$1,000 penalty applies. Out-of-network <u>allowed amounts</u> for Facility Fees are limited to \$760 per date of service
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay per visit, deductible</u> does not apply.	\$150 <u>copay per visit, deductible</u> does not apply.	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	* <u>Network deductible</u> applies	

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	<u>Urgent care</u>	\$40 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	Virtual visits - No Charge by a Designated Virtual Network Provider. No virtual coverage out-of-network If you receive services in addition to Urgent care visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery. <u>Preauthorization</u> is required out-of-network or no coverage.
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	<u>Network</u> Partial hospitalization/intensive outpatient treatment: 20% <u>coinsurance</u> . <u>Preauthorization</u> is required out-of-network for certain services or no coverage. See your policy or <u>plan</u> document for additional information about EAP benefits.
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required out-of-network or no coverage. See your policy or <u>plan</u> document for additional information about EAP benefits.
	Office visits	No Charge	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Inpatient <u>preauthorization</u> applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or no coverage.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 100 visits per calendar year. Out-of-network allowed amounts for Home health care are limited to \$150 per visit. <u>Preauthorization</u> is required out-of-network or a \$1,000 penalty applies.
	Home health care	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Outpatient rehabilitation services are unlimited per calendar year. No limits apply for treatment of Autism Spectrum Disorder Services. No coverage out-of-network for physical and occupational therapy.
If you need help recovering or have other special health needs	Rehabilitation services	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	

* For more information about limitations and exceptions, see the plan or policy document at welcometouh.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Habilitative services</u>	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply.	50% <u>coinsurance</u>	Services are provided under <u>Rehabilitation Services</u> above. No limits apply for treatment of Autism Spectrum Disorder Services. No coverage <u>out-of-network</u> for physical and occupational therapy.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 100 days per calendar year. <u>Preauthorization</u> is required <u>out-of-network</u> or a \$1,000 penalty applies.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	No coverage <u>out-of-network</u> for durable medical equipment
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility or a \$1,000 penalty applies.
If your child needs dental or eye care	Children's eye exam	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Limited to 1 exam every 24 months. No coverage <u>out-of-network</u> .
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

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.)	
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care • Glasses 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when travelling outside - the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none"> • Acupuncture – 20 visits per calendar year • Bariatric surgery 	<ul style="list-style-type: none"> • Private duty nursing • Routine foot care – Except as covered for Diabetes
<ul style="list-style-type: none"> • Chiropractic (Manipulative care) – 24 visits per calendar year • Hearing aids - \$2,500 per calendar year 	<ul style="list-style-type: none"> • Routine eye care (adult) - 1 exam per 24 months • Weight loss programs – Real Appeal

* For more information about limitations and exceptions, see the plan or policy document at welcometouhnc.com.

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 is: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhcc.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: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or 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.dmhcc.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 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinekehgo shika a'ohwol ninisingo, kwijigo holne' 1-866-633-2446.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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 in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$500
- Specialist copay \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,470

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$500
- Specialist copay \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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 \$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$150
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$850

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$500
- Specialist copay \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900

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

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意： 如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LUU Y: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đãi thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال برقم الهاتف المجاني المدرج داخل مخلص المزاي والتغطية هذا. (Summary of Benefits and Coverage, SBC)

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage, SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខកតចេញថ្លៃ ដែលមានកន្លែងសេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការបំពេញ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saitaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyanam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍI BAA'ÁKONÍZIN: Diné (Navajo) bizaad bee yáni'ti'go, saad bee áka'anída'awo'ígíí, t'áá jík'eh, bee ná'ahóót'i'. T'áá shóodí Naaltsoos Bee 'Aa'áhayání dóo Bee 'Ak'é'asti' Bee Baa Hane'i (Summary of Benefits and Coverage, SBC) biyi' t'áá jík'ehgo béesh bee hane'i bika'ígíí bee hodílnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).



English

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in your language, first call your insurance company's phone number at 1-800-842-2656. Someone who speaks your language can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

Español

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su compañía de seguros. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su compañía de seguros al 1-800-842-2656.

Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame a la línea directa del Departamento de seguros al 1-800-927-4357. (Spanish)

中文

重要事項: 您與您的醫生或醫療保險公司交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請先致電您的保險公司，電話號碼 1-800-842-2656
說中文人士將為您提供協助。如需更多協助，請致電保險部熱線 1-800-927-4357 (Chinese)

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

注意事項：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर दिए टोल-फ्री फोन नंबर पर काल करें।

CEEBOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (Khmer-Cambodian) សូមទូរស័ព្ទទៅលេខកំរិតតម្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

Ընդհանուր թեթև հայերեն (Armenian) եք խոսում, անվճար լեզվական օգնության ծառայություններ են հասանելի Ձեզ: Խոսողովու՜մ է՝ զանգահարե՛լ անվճար հեռախոսահամարով, որը նշվել է Ձեր ճանաչողական քարտի վրա:

ਪਿਅਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ 'ਸਾਸਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ' ਸ਼ਿਲਬੁਲ ਮੁੜਤ ਉਪਲਬਧ ਹਨ। ਵਿਰਮਾ ਕਰਕੇ ਆਪਣੇ ਪਾਠਾਣ-ਪੱਤਰ 'ਤੇ ਦਿੱਤੇ ਗਏ ਟੈਲ ਗ੍ਰੈ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

ໂປຣຕຣາບ: ຫາກທ່ານເຜີຍທາຍາໄທຍ (Thai) ມີບຣິກາຣຄວາມຊ່ວຍເຫຼືອດ້ານທາຍາໃຫ້ແກ່ທ່ານໂດຍທີ່ທ່ານບໍ່ຕ້ອງເສີຍຄ່າໃຊ້ຈ່າຍແຕ່ອາຍາງໃດ ໂປຣຕຣ໌ທຣີທັງທ່ານເລຂໂທຣທຣີທີ່ອາຍາບໍ່ມີດຣປຣະຈ່າດ້ວຍທ່ານ

Select Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Select Plus
 <p>Network coverage only You can usually save money when you receive care for covered health care services from network providers.</p>	<input type="checkbox"/>
 <p>Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.</p>	<input checked="" type="checkbox"/>
 <p>Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.</p>	<input type="checkbox"/>
 <p>Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.</p>	<input type="checkbox"/>
 <p>Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.</p>	<input checked="" type="checkbox"/>
 <p>Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.</p>	<input checked="" type="checkbox"/>
 <p>Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.</p>	<input type="checkbox"/>
 <p>Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.</p>	<input type="checkbox"/>
 <p>Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.</p>	<input type="checkbox"/>

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Select Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	\$500	\$5,000
Family	\$1,000	\$10,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

	In Network	Out-of-Network
Annual Out-of-Pocket Limit		
Individual	\$2,500	\$10,000
Family	\$5,000	\$20,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

The below references to Certificate of Coverage (COC) is the same as Evidence of Coverage (EOC) throughout this Benefit Summary.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care		No copay	Not covered
<p>Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.</p> <p>Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.</p>			
Office Services - Sickness & Injury			
Primary Care Physician		\$20 copay	50%*
<p>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.</p>			
Specialist		\$40 copay	50%*
<p>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.</p>			
Urgent Care		\$40 copay	50%*
<p>Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.</p>			

*After the Annual Medical Deductible has been met.

†Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Designated Network	Network	Out-of-Network
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Virtual Care Services

No copay

Not covered

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.

Vision Exams

\$20 copay

Not covered

Limited to 1 exam every 24 months.

Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.

Emergency Care

Emergency Ambulance

20%*

20%*

Non-Emergency Ambulance¹

20%*

50%*

Accidental Dental and Oral Surgery

20%*

20%*

Emergency Room

\$150 copay

\$150 copay

Inpatient Care

Congenital Heart Disease Surgeries¹

20%*

50%*

Hospital Inpatient Stays¹

20%*

50%*

Inpatient Habilitative Services¹

The amount you pay is based on where the covered health care service is provided.

Skilled Nursing Facility & Inpatient Rehabilitation Facility Services¹

20%*

50%*

Limited to 100 days per year in a Skilled Nursing Facility.

Outpatient Care

Habilitative Services and Manipulative Treatment

\$20 copay

50%*

Limited to 24 visits of manipulative treatments per year.

Limits will be the same as, and combined with those stated under Rehabilitation Services.

Out-of-Network Benefits are not available for physical therapy, occupational therapy, and Manipulative Treatments.

Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Designated Network	Network	Out-of-Network
Home Health Care ¹		20%*	50%*
<i>Limited to 100 visits per year.</i>			
<i>For Out-of-Network benefits, Allowed Amounts are limited to \$150 per visit.</i>			
<i>One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.</i>			
Lab Testing ¹	No copay	No copay	Not covered
Major Diagnostic and Imaging ¹		20%*	50%*
Physician Fees for Surgical and Medical Services		20%*	50%*
Rehabilitation Services		\$20 copay	50%*
<i>Limited to 24 visits of manipulative treatments per year.</i>			
<i>Out-of-Network Benefits are not available for physical therapy, occupational therapy, and Manipulative Treatments.</i>			
<i>Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.</i>			
<i>Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.</i>			
Scopic Procedures		20%*	50%*
<i>Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.</i>			
Surgery ¹		20%*	50%*
<i>For Out-of-Network Benefits, Allowed Amount for Facility Fees are limited to \$760 per date of service.</i>			
Therapeutic Treatments ¹		20%*	50%*
<i>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.</i>			
<i>Out-of-Network Benefits are not available for dialysis services.</i>			
X-ray and other Diagnostic Testing ¹		No copay	50%*
Supplies and Services			
Diabetes Self-Management and Training ¹		The amount you pay is based on where the covered health care service is provided.	
<i>For Self-Management and Training, cost sharing will not exceed the costs for Physician office visit.</i>			
Durable Medical Equipment, Orthotics and Supplies		20%*	Not covered
Enteral Nutrition		20%*	50%*

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Designated Network	Network	Out-of-Network
Hearing Aids		20%*	50%*
<i>Limited to \$2,500 every year.</i>			
<i>Benefits are further limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.</i>			
Ostomy Supplies		20%*	Not covered
Pharmaceutical Products		20%*	50%*
<i>Administered on an outpatient basis in a Hospital, Alternate Facility or doctor's office.</i>			
Prosthetic Devices ¹		20%*	50%*
<i>Limited to a single purchase of each type of prosthetic device every three years.</i>			
<i>Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.</i>			
Urinary Catheters		20%*	Not covered
Pregnancy			
Maternity Services ¹		The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.
<i>We pay for Covered Health Care Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is no cost share for this Benefit.</i>			
<i>Benefits for office visits for prenatal care received from a Network provider are covered without cost sharing during the entire course of your pregnancy.</i>			
<i>All maternity items and services that are recommended preventive care and are required to be covered under the Affordable Care act, will be provided without cost share. Please refer to Preventive Care Services.</i>			
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient ¹		20%*	50%*
Outpatient ¹		\$20 copay	50%*
Partial Hospitalization ¹		20%*	50%*

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Other Services			
Acupuncture Treatment <i>In Network: Limited to 20 treatments per year.</i>		\$20 copay	Not covered
Cellular or Gene Therapy <i>For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.</i>		The amount you pay is based on where the covered health care service is provided.	Not covered
Clinical Trials ¹		The amount you pay is based on where the covered health care service is provided.	
Dental Anesthesia Services <i>Limited to Covered Persons who are one of the following: a child under seven years of age; a person who is developmentally disabled regardless of age; a person whose health is compromised and for whom general anesthesia is required, regardless of age.</i>		20%*	50%*
Diabetes Treatment <i>Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.</i>		The amount you pay is based on where the covered health care service is provided. See prescription drug benefit and Durable Medical Equipment (DME), Orthotics and Supplies for coverage of diabetes equipment and supplies.	
Fertility Preservation for Iatrogenic Infertility ¹ <i>Limited to \$20,000 per Covered Person per lifetime. Limited to \$5,000 for Prescription Drug Products per Covered Person. This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Agreement.</i>		20%*	50%*
Gender Dysphoria		The amount you pay is based on where the covered health care service is provided.	
Hospice Care ¹		20%*	50%*
Mastectomy Services ¹		The amount you pay is based on where the covered health care service is provided.	
Obesity - Weight Loss Surgery ¹ <i>For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.</i>	The amount you pay is based on where the covered health care service is provided.		Not covered
Off-Label Drug Use and Experimental or Investigational Services		The amount you pay is based on where the covered health care service is provided.	
Osteoporosis Services		The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Designated Network	Network	Out-of-Network
Preimplantation Genetic Testing (PGT) and Related Services ¹		20%*	50%*
<p><i>Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.</i></p> <p><i>Benefits for related services are limited to one Assisted Reproductive Technology (ART) procedure during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include the Preimplantation Genetic Testing (PGT) for the specific genetic disorder.</i></p>			
Reconstructive Procedures ¹		The amount you pay is based on where the covered health care service is provided.	
Telehealth Services		The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint (TMJ) Services ¹		The amount you pay is based on where the covered health care service is provided.	
Transplantation Services ¹		The amount you pay is based on where the covered health care service is provided.	Not covered
<p><i>Network Benefits must be received from a Designated Provider.</i></p>			

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Access

In Network and Out of Network

Annual Pharmacy Deductible	
Individual	You do not have to pay a pharmacy deductible
Family	You do not have to pay a pharmacy deductible

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail Network	Out-of-Network Pharmacy	Mail Order Network Pharmacy**
Tier 1 \$	\$5	\$5	\$10
Tier 2 \$\$	\$20	\$20	\$40
Tier 3 \$\$\$	\$50	\$50	\$100

* After the Annual Medical Deductible has been met.

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com[®] or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com[®] or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

Here's an example of how the plan's costs come into play.

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, \$15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.



Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to [welcometouhc.com](https://www.welcometouhc.com) > **Benefits** > **Find a Doctor or Facility**.
- Choose **Search for a health plan**.
- Choose **Select Plus** to view providers in the health plan's network.



Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to [welcometouhc.com](https://www.welcometouhc.com) > **Benefits** > **Pharmacy Benefits**.
- Select **Access** to view the medications that are covered under your plan.



Access your plan online.

With [myuhc.com](https://www.myuhc.com)®, you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.



Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.



Other important information about your benefits.

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Private-Duty Nursing
- Weight Loss Programs
- Long-Term Care
- Cosmetic Surgery
- Non-emergency care when traveling outside the U.S.
- Infertility Treatment
- Glasses
- Routine Foot Care
- Dental Care (Adult/Child)

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

Certain Preventative Care Medications may be covered at zero costshare. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

- Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the Certificate.
- Any product prescription or non-prescription for which the primary use is a source of dietary or nutritional products, nutritional supplements, or dietary management of disease, including vitamins (except prenatal) minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicines and prescription medical food products even when used for the treatment of a health condition, except as described under Phenylketonuria (PKU) Treatment in the Evidence of Coverage, except as required by dietary or dietary or state mandate. Phenylketonuria (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Network Physician provided that the diet is Medically Necessary. This exclusion does not apply to authorized Medically Necessary services to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).
- Drugs available over-the-counter. This exclusion does not apply to prescribed over-the-counter FDA-approved contraceptives or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a provider for which Benefits are available, without cost sharing, as described under Section 5 of the Combined Evidence of Coverage and Disclosure Form.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental or Investigational or Unproven Services and medications.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- Certain Prescription Drug Products for tobacco cessation.
- Certain compounded drugs.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Growth hormone therapy unless required by state law.
- Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.
- Prescription Drug Products when prescribed as sleep aids.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.

UnitedHealthcare does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at:
<http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us such as letters in others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (**Vietnamese**), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어 (**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (**Tagalog**), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русский (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تويوغللا تدهاسمل تامدخ ناف، (Arabic)، تيبرعل اشدحت تنك اذا: هيمنت
ىل ع جردملا يئاجملا فتاهل مقرب لاصتال اىجرى. لئل عحاتم تيئاجملا
كئب فصا خلا فيرعتملا قاطب

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (**French**), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (**Polish**), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (**Portuguese**), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (**Italian**), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (**German**) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते हैं, आपको भाषा सहायता सेवाएं, नःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर काल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (**Hmong**), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά (**Greek**), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

PAKDAAR: Nu saritaem ti llocano (**Ilocano**), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍI BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yánilti`go, saad bee áka`anída`awo`ígíí, t`áá jííik`eh, bec ná`ahóót`i`. T`áá shqoqí ninaaltsoos nitl`izi bee nééhozinígíí bine`dęé` t`áá jííik`ehgo béesh bee hane`i biká`ígíí bee hodíílnih.

OGOW: Haddii aad ku hadasho Soomaali (**Somali**), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

ગુજરાતી (Gujarati): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપ્ય છ. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિપર આપેલા સભ્ય માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.



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, call 1-866-314-0335 or visit welcometouhc.com. 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 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$1,500 Individual / \$3,000 Family Out-of-Network: \$5,000 Individual / \$10,000 Family Per calendar year.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is 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 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?	Network: \$3,000 Individual / \$6,000 Family Out-of-Network: \$10,000 Individual / \$20,000 Family Per calendar year.	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?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	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 myuhc.com or call 1-866-314-0335 for a list of network 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 an out-of-network 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 network provider might use an out-of-network 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?	No.	You can see the specialist you choose without a referral.



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
		Network Provider (You will pay the least)	Out-of-Network 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% <u>coinsurance</u>	50% <u>coinsurance</u>	Virtual visits - 0% <u>coinsurance</u> by a Designated Virtual Network Provider. No virtual coverage <u>out-of-network</u>
	Specialist visit	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for. No coverage <u>out-of-network</u>
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Lab Testing: Not Covered X-Ray/Diagnostic: 50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or a \$1,000 penalty applies. No coverage <u>out-of-network</u> for lab testing
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or a \$1,000 penalty applies.
If you need drugs to treat your illness or condition More information about <u>prescription</u> drug coverage is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: \$5 <u>copay</u> Mail-Order: \$10 <u>copay</u>	Retail: \$5 <u>copay</u>	<u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy. You may need to obtain certain drugs, including certain <u>specialty</u> drugs, from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. If you use an <u>out-of-network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered.
	Tier 2 – Your Mid-Range Cost Option	Retail: \$20 <u>copay</u> Mail-Order: \$40 <u>copay</u>	Retail: \$20 <u>copay</u>	You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Prescription drug costs are subject to the annual <u>deductible</u> . <u>Network deductible</u> will be applied to the <u>out-of-network provider</u> and applies to the <u>Network out-of-pocket limit</u>
	Tier 3 – Your Mid-Range Cost Option	Retail: \$50 <u>copay</u> Mail-Order: \$100 <u>copay</u>	Retail: \$50 <u>copay</u>	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required <u>out-of-network</u> for certain services or a \$1,000 penalty applies. <u>Out-of-network allowed amounts</u> for Facility Fees are limited to \$760 per date of service
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
	Emergency room care	20% coinsurance	*20% coinsurance	* <u>Network deductible</u> applies
If you need immediate medical attention	<u>Emergency medical transportation</u>	20% coinsurance	*20% coinsurance	* <u>Network deductible</u> applies
	<u>Urgent care</u>	20% coinsurance	50% coinsurance	Virtual visits - 0% <u>coinsurance</u> by a Designated Virtual Network Provider. No virtual coverage <u>out-of-network</u>
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	<u>Preauthorization</u> is required <u>out-of-network</u> or no coverage.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 20% <u>coinsurance</u> . <u>Preauthorization</u> is required <u>out-of-network</u> for certain services or no coverage. See your policy or <u>plan</u> document for additional information about EAP benefits.
	Inpatient services	20% coinsurance	50% coinsurance	<u>Preauthorization</u> is required <u>out-of-network</u> or no coverage. See your policy or <u>plan</u> document for additional information about EAP benefits.
If you are pregnant	Office visits	No Charge	50% coinsurance	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Inpatient preauthorization applies <u>out-of-network</u> if stay exceeds 48 hours (C-Section: 96 hours) or no coverage.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 100 visits per calendar year. <u>Out-of-network</u> allowed amounts for Home health care are limited to \$150 per visit. <u>Preauthorization</u> is required <u>out-of-network</u> or a \$1,000 penalty applies.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Outpatient rehabilitation services are unlimited per calendar year. No limits apply for treatment of Autism Spectrum Disorder Services. No coverage <u>out-of-network</u> for physical and occupational therapy.
	<u>Habilitative services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Services are provided under Rehabilitation Services above. No limits apply for treatment of Autism Spectrum Disorder Services. No coverage <u>out-of-network</u> for physical and occupational therapy.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 100 days per calendar year. <u>Preauthorization</u> is required <u>out-of-network</u> or a \$1,000 penalty applies.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	No coverage <u>out-of-network</u> for <u>durable medical equipment</u> .
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility or a \$1,000 penalty applies.
	Children's eye exam	20% <u>coinsurance</u>	Not Covered	Limited to 1 exam every 24 months. No coverage <u>out-of-network</u> .
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

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.)	
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care • Glasses 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when travelling outside - the U.S.
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none"> • Acupuncture – 20 visits per calendar year • Bariatric surgery 	<ul style="list-style-type: none"> • Private duty nursing • Routine foot care – Except as covered for Diabetes • Routine eye care (adult) - 1 exam per 24 months • Weight loss programs – Real Appeal

* For more information about limitations and exceptions, see the [plan](#) or policy document at welcometouch.com.

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 is: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhcc.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: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or 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.dmhcc.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 1-866-314-0335.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-314-0335.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-314-0335.

Navajo (Dine): Dine'ehgo shika a'ohwol ninisingo, kwijigo holne' 1-866-314-0335.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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 in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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 \$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,990

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,810

We do not treat members differently because of sex, age, race, color, disability or national origin.

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Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

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You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意： 如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LUU Y: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đãi thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال برقم الهاتف المجاني المدرج داخل مخلص المزاي والتغطية هذا. (Summary of Benefits and Coverage, SBC)

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage, SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខកតចេញថ្លៃ ដែលមានកន្លែងសេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការបំពេញ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saitaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyanam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍI BAA'ÁKONÍZIN: Diné (Navajo) bizaad bee yáni'ti'go, saad bee áka'anída'awo'ígíí, t'áá jík'eh, bee ná'ahóót'i'. T'áá shóodí Naaltsoos Bee 'Aa'áhayání dóo Bee 'Ak'é'asti' Bee Baa Hane'i (Summary of Benefits and Coverage, SBC) biyi' t'áá jík'ehgo béesh bee hane'i bika'ígíí bee hodíinih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).



English

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in your language, first call your insurance company's phone number at 1-800-842-2656. Someone who speaks your language can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

Español

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su compañía de seguros. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su compañía de seguros al 1-800-842-2656.

Alguien que habla español puede ayudarlo. Si necesita ayuda adicional, llame a la línea directa del Departamento de seguros al 1-800-927-4357. (Spanish)

中文

重要事項: 您與您的醫生或醫療保險公司交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請先致電您的保險公司，電話號碼 1-800-842-2656
說中文人士將為您提供協助。如需更多協助，請致電保險部熱線 1-800-927-4357 (Chinese)

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

注意事項：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर दिए टोल-फ्री फोन नंबर पर काल करें।

CEEBOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (Khmer-Cambodian) សូមទូរស័ព្ទទៅលេខកំរិតកំរិត ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។










ԸՆԴՀԱՆՈՒԹՅԱՆ ԵՐԵԿ ՀԱՅԿԵՐԵՆ (Armenian) եք խոսում, անվճար լեզվական օգնության ծառայություններ են հասանելի Ձեզ: Խոսողը և՛ զանգահարել և՛ անվճար հեռախոսահամարով, որը նշվել է Ձեր ճանաչողական քարտի վրա:

ਪਿਅਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਵਿਰਾਮ ਕਰਕੇ ਆਪਣੇ ਪਾਠਾਣ-ਪੱਤਰ 'ਤੇ ਦਿੱਤੇ ਗਏ ਟੈਲ ਗ੍ਰੈ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

ໂປຣຕຣາບ: ຫາກທ່ານເຜີຍທາຍາໄທຍ (Thai) ມີບຸຣິກາຣຄວາມຊ່ວຍເຫຼືອດ້ານທາຍາໃຫ້ແກ່ທ່ານໂດຍທີ່ທ່ານບໍ່ຕ້ອງເສີຍຄ່າໃຊ້ຈ່າຍແຕ່ອາຍາງໃດ ໂປຣຕຣ໌ທຣີທັງທ່ານເລຂໂທຣທຣີທີ່ອາຍາບນນັດຣປຣະຈ່າດ້ວຍທ່ານ

Select Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Select Plus
 <p>Network coverage only You can usually save money when you receive care for covered health care services from network providers.</p>	<input type="checkbox"/>
 <p>Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.</p>	<input checked="" type="checkbox"/>
 <p>Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.</p>	<input type="checkbox"/>
 <p>Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.</p>	<input type="checkbox"/>
 <p>Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.</p>	<input checked="" type="checkbox"/>
 <p>Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.</p>	<input checked="" type="checkbox"/>
 <p>Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.</p>	<input type="checkbox"/>
 <p>Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.</p>	<input type="checkbox"/>
 <p>Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.</p>	<input checked="" type="checkbox"/>

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Select Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Single Coverage	\$1,500	\$5,000
Family Coverage	\$3,000	\$10,000

No one in the family is eligible for benefits until the family coverage deductible is met.

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

	In Network	Out-of-Network
Annual Out-of-Pocket Limit		
Individual	\$3,000	\$10,000
Family	\$6,000	\$20,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

The below references to Certificate of Coverage (COC) is the same as Evidence of Coverage (EOC) throughout this Benefit Summary.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care		No copay	Not covered
<p>Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.</p> <p>Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.</p>			
Office Services - Sickness & Injury			
Primary Care Physician		20%*	50%*
<p>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.</p>			
Specialist		20%*	50%*
<p>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.</p>			
Urgent Care		20%*	50%*
<p>Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.</p>			

*After the Annual Medical Deductible has been met.

†Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Designated Network	Network	Out-of-Network
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Virtual Care Services

No copay*

Not covered

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.

Vision Exams

20%*

Not covered

Limited to 1 exam every 24 months.

Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.

Emergency Care

Emergency Ambulance

20%*

20%*

Non-Emergency Ambulance¹

20%*

50%*

Accidental Dental and Oral Surgery

20%*

20%*

Emergency Room

20%*

20%*

Inpatient Care

Congenital Heart Disease Surgeries¹

20%*

50%*

Hospital Inpatient Stays¹

20%*

50%*

Inpatient Habilitative Services¹

The amount you pay is based on where the covered health care service is provided.

Skilled Nursing Facility & Inpatient Rehabilitation Facility Services¹

20%*

50%*

Limited to 100 days per year in a Skilled Nursing Facility.

Outpatient Care

Habilitative Services and Manipulative Treatment

20%*

50%*

Limited to 24 visits of manipulative treatments per year.

Limits will be the same as, and combined with those stated under Rehabilitation Services.

Out-of-Network Benefits are not available for physical therapy, occupational therapy, and Manipulative Treatments.

Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Designated Network	Network	Out-of-Network
Home Health Care ¹		20%*	50%*
<i>Limited to 100 visits per year.</i>			
<i>For Out-of-Network benefits, Allowed Amounts are limited to \$150 per visit.</i>			
<i>One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.</i>			
Lab Testing ¹		20%*	Not covered
Major Diagnostic and Imaging ¹		20%*	50%*
Physician Fees for Surgical and Medical Services		20%*	50%*
Rehabilitation Services		20%*	50%*
<i>Limited to 24 visits of manipulative treatments per year.</i>			
<i>Out-of-Network Benefits are not available for physical therapy, occupational therapy, and Manipulative Treatments.</i>			
<i>Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.</i>			
<i>Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.</i>			
Scopic Procedures		20%*	50%*
<i>Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.</i>			
Surgery ¹		20%*	50%*
<i>For Out-of-Network Benefits, Allowed Amount for Facility Fees are limited to \$760 per date of service.</i>			
Therapeutic Treatments ¹		20%*	50%*
<i>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.</i>			
<i>Out-of-Network Benefits are not available for dialysis services.</i>			
X-ray and other Diagnostic Testing ¹		20%*	50%*
Supplies and Services			
Diabetes Self-Management and Training ¹		The amount you pay is based on where the covered health care service is provided.	
<i>For Self-Management and Training, cost sharing will not exceed the costs for Physician office visit.</i>			
Durable Medical Equipment, Orthotics and Supplies		20%*	Not covered
Enteral Nutrition		20%*	50%*

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Designated Network	Network	Out-of-Network
Hearing Aids		20%*	50%*
<i>Limited to \$2,500 every year.</i>			
<i>Benefits are further limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.</i>			
Ostomy Supplies		20%*	Not covered
Pharmaceutical Products		20%*	50%*
<i>Administered on an outpatient basis in a Hospital, Alternate Facility or doctor's office.</i>			
Prosthetic Devices ¹		20%*	50%*
<i>Limited to a single purchase of each type of prosthetic device every three years.</i>			
<i>Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.</i>			
Urinary Catheters		20%*	Not covered
Pregnancy			
Maternity Services ¹		The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.
<i>We pay for Covered Health Care Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is no cost share for this Benefit.</i>			
<i>Benefits for office visits for prenatal care received from a Network provider are covered without cost sharing during the entire course of your pregnancy.</i>			
<i>All maternity items and services that are recommended preventive care and are required to be covered under the Affordable Care act, will be provided without cost share. Please refer to Preventive Care Services.</i>			
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient ¹		20%*	50%*
Outpatient ¹		20%*	50%*
Partial Hospitalization ¹		20%*	50%*

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Other Services			
Acupuncture Treatment		20%*	Not covered
<i>In Network: Limited to 20 treatments per year.</i>			
Cellular or Gene Therapy		The amount you pay is based on where the covered health care service is provided.	Not covered
<i>For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.</i>			
Clinical Trials ¹		The amount you pay is based on where the covered health care service is provided.	
Dental Anesthesia Services		20%*	50%*
<i>Limited to Covered Persons who are one of the following: a child under seven years of age; a person who is developmentally disabled regardless of age; a person whose health is compromised and for whom general anesthesia is required, regardless of age.</i>			
Diabetes Treatment		The amount you pay is based on where the covered health care service is provided. See prescription drug benefit and Durable Medical Equipment (DME), Orthotics and Supplies for coverage of diabetes equipment and supplies.	
<i>Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.</i>			
Fertility Preservation for Iatrogenic Infertility ¹		20%*	50%*
<i>Limited to \$20,000 per Covered Person per lifetime.</i>			
<i>Limited to \$5,000 for Prescription Drug Products per Covered Person.</i>			
<i>This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Agreement.</i>			
Gender Dysphoria		The amount you pay is based on where the covered health care service is provided.	
Hospice Care ¹		20%*	50%*
Mastectomy Services ¹		The amount you pay is based on where the covered health care service is provided.	
Obesity - Weight Loss Surgery ¹	The amount you pay is based on where the covered health care service is provided.		Not covered
<i>For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.</i>			
Off-Label Drug Use and Experimental or Investigational Services		The amount you pay is based on where the covered health care service is provided.	
Osteoporosis Services		The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Designated Network	Network	Out-of-Network
Preimplantation Genetic Testing (PGT) and Related Services ¹		20%*	50%*
<p><i>Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.</i></p> <p><i>Benefits for related services are limited to one Assisted Reproductive Technology (ART) procedure during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include the Preimplantation Genetic Testing (PGT) for the specific genetic disorder.</i></p>			
Reconstructive Procedures ¹		The amount you pay is based on where the covered health care service is provided.	
Telehealth Services		The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint (TMJ) Services ¹		The amount you pay is based on where the covered health care service is provided.	
Transplantation Services ¹		The amount you pay is based on where the covered health care service is provided.	Not covered
<p><i>Network Benefits must be received from a Designated Provider.</i></p>			

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Advantage

In Network and Out of Network

Annual Pharmacy Deductible	
Individual	See the Annual Medical Deductible section
Family	See the Annual Medical Deductible section

The Pharmacy Deductible is the amount you pay for pharmacy expenses per year before you begin to receive Pharmacy Benefits.

Annual Deductible - Network and Out-of-Network

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail Network	Out-of-Network Pharmacy	Mail Order Network Pharmacy**
Tier 1 \$	\$5*	\$5*	\$10*
Tier 2 \$\$	\$20*	\$20*	\$40*
Tier 3 \$\$\$	\$50*	\$50*	\$100*

* After the Annual Medical Deductible has been met.

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com[®] or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com[®] or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

Here's an example of how the plan's costs come into play.

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, \$15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.



Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to [welcometouhc.com](https://www.welcometouhc.com) > **Benefits** > **Find a Doctor or Facility**.
- Choose **Search for a health plan**.
- Choose **Select Plus** to view providers in the health plan's network.



Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to [welcometouhc.com](https://www.welcometouhc.com) > **Benefits** > **Pharmacy Benefits**.
- Select **Advantage** to view the medications that are covered under your plan.



Access your plan online.

With [myuhc.com](https://www.myuhc.com)®, you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.



Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.



Other important information about your benefits.

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Private-Duty Nursing
- Weight Loss Programs
- Long-Term Care
- Cosmetic Surgery
- Non-emergency care when traveling outside the U.S.
- Infertility Treatment
- Glasses
- Routine Foot Care
- Dental Care (Adult/Child)

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

Certain Preventative Care Medications may be covered at zero costshare. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

- Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the Certificate.
- Any product prescription or non-prescription for which the primary use is a source of dietary or nutritional products, nutritional supplements, or dietary management of disease, including vitamins (except prenatal) minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicines and prescription medical food products even when used for the treatment of a health condition, except as described under Phenylketonuria (PKU) Treatment in the Evidence of Coverage, except as required by dietary or dietary or state mandate. Phenylketonuria (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Network Physician provided that the diet is Medically Necessary. This exclusion does not apply to authorized Medically Necessary services to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).
- Drugs available over-the-counter. This exclusion does not apply to prescribed over-the-counter FDA-approved contraceptives or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a provider for which Benefits are available, without cost sharing, as described under Section 5 of the Combined Evidence of Coverage and Disclosure Form.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental or Investigational or Unproven Services and medications.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- Certain Prescription Drug Products for tobacco cessation.
- Certain compounded drugs.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Growth hormone therapy unless required by state law.
- Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.
- Prescription Drug Products when prescribed as sleep aids.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.

UnitedHealthcare does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at:
<http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us such as letters in others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (**Vietnamese**), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어 (**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (**Tagalog**), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русский (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تويوغللا تددعاسمل تامدخ ناف، (Arabic)، تيبرعل اشدحت تنك اذا: هيمنت
ىل ع جردملا يئاجملا فتاهل مقرب لاصتال اىجرى. لئل عحاتم تيئاجملا
كئب فصا خلا فيرعتل ا قاطب

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (**French**), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (**Polish**), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (**Portuguese**), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (**Italian**), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (**German**) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते हैं, आपको भाषा सहायता सेवाएं, नःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर काल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (**Hmong**), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά (**Greek**), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

PAKDAAR: Nu saritaem ti llocano (**Ilocano**), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍI BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yánilti`go, saad bee áka`anída`awo`ígíí, t`áá jííik`eh, bec ná`ahóót`i`. T`áá shqoqí ninaaltsoos nítl`izi bee nééhozinígíí bine`dęé` t`áá jííik`ehgo béésh bee hane`i biká`ígíí bee hodíílnih.

OGOW: Haddii aad ku hadasho Soomaali (**Somali**), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

ગુજરાતી (Gujarati): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપ્ય છ. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિપર આપેલા સેભ્ય માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

ATTACHMENT 2

[Home](#) > [Newsroom](#) > [CalPERS News](#)
> [CalPERS Announces Health Plan Premiums for 2026](#)

CalPERS Announces Health Plan Premiums for 2026

July 15, 2025

Communications & Stakeholder Relations

Office of Public Affairs

(916) 795-3991 - newsroom@calpers.ca.gov

SACRAMENTO, Calif. – The CalPERS Board of Administration approved health plan premiums for the calendar year 2026 today, with an overall weighted premium rate increase of 8.21%.

The rate increase for Basic (non-Medicare) plans will average 7.76%. Members enrolled in CalPERS' Basic Health Maintenance Organization (HMO) plans will have an average premium rate increase of 6.48%. Preferred Provider Organization (PPO) Basic plans will have an overall rate increase of 12.08%. Medicare plan premiums will see an average increase of 10.78% overall.

“The continued rise in costs across the health care landscape remains a significant challenge for purchasers such as CalPERS, but we remain committed to meeting this challenge by providing access to high-quality, equitable care that improves health outcomes while pursuing innovative strategies to manage costs,” said Ramón Rubalcava, chair of the Pension and Health Benefits Committee.

Pharmacy costs continue to drive rate changes across plans as utilization and unit costs increase, particularly with specialty and brand name drugs. For Medicare premiums, revenue changes from the Centers for Medicare and Medicaid Services (CMS) and increased

utilization of medical services further impact costs for both Medicare Advantage and Medicare Supplemental plans.

“Each year, we carefully evaluate our plans to ensure they offer high-value care that improves health outcomes, emphasizes prevention, and effectively manages costs,” said CalPERS Chief Health Director Don Moulds. “We know that premium increases can be a challenge, and Open Enrollment is a chance for members to review their benefits and select a plan that supports their health and budget.”


CalPERS will also be replacing Blue Shield’s Trio plan with Access+ HMO in Monterey County to help ensure the viability of lower cost health plan options for our membership in the face of significant regional price variation. In addition, members in the PERS Gold PPO plan can continue to receive in-patient deductible credits of up to \$500 for completing an expanded menu of preventive care activities including cancer and depression screenings, vaccinations, among others.

The following tables represent the overall percentage premium change for each health plan between 2025 and 2026 using the state, single-party premium.

Basic Plans	% Premium Change
Anthem Blue Cross Select HMO	6.78%
Anthem Blue Cross Traditional HMO	4.88%
Blue Shield Access+ HMO and EPO	12.70%
Blue Shield Trio	3.02%
Health Net Salud y Más HMO	4.70%
Kaiser Permanente HMO	5.05%
Kaiser Permanente HMO Out-of-State	-1.64%
PERS Gold PPO	10.56%

Basic Plans	% Premium Change
PERS Platinum PPO	13.24%
Sharp Performance Plus HMO	5.50%
UnitedHealthcare Alliance HMO	9.03%
UnitedHealthcare Harmony HMO	12.28%
Western Health Advantage HMO	6.05%
Total Basic Weighted Average Change	7.76%

Medicare Plans	% Premium Change
Anthem Medicare Preferred PPO	17.26%
Blue Shield Medicare PPO	20.33%
Kaiser Permanente Senior Advantage	4.01%
Kaiser Permanente Senior Advantage Out-of-State	3.99%
Kaiser Permanente Senior Advantage Summit	4.41%
Kaiser Permanente Senior Advantage Summit Out-of-State	4.40%
PERS Gold Medicare Supplement	9.42%
PERS Platinum Medicare Supplement	13.82%
Sharp Direct Advantage HMO	6.95%
UnitedHealthcare Group Medicare Advantage PPO	8.83%
Total Medicare Weighted Average Change	10.78%

CalPERS members can shop health plans and make changes during [Open Enrollment](#), which runs September 15 through October 10. Beginning September 8, members can find Open Enrollment information on the CalPERS website and customized information in their myCalPERS accounts. Using the Search Health Plans tool in [myCalPERS](#) , members can compare plan monthly premiums and copays, and search for primary care doctors and specialists to see which plan works best for them. Premiums will take effect January 1, 2026.

About CalPERS

For more than nine decades, CalPERS has built retirement and health security for state, school, and public agency members who invest their lifework in public service. Our pension fund serves more than 2 million members in the CalPERS retirement system, making us the largest defined-benefit public pension in the nation. We also administer health benefits for more than 1.5 million members and their families, making CalPERS the nation's largest purchaser of public employee health services behind the U.S. government.

Updated: July 15, 2025



We serve those who serve California.

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State of California

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ATTACHMENT 3

DECLARATION OF CRAIG GOTT

I, Craig Gott, declare and state:

1. I am President of Suburban Water Systems. I am an officer of Suburban Water Systems.

2. I have reviewed and/or am familiar with the materials contained in Suburban Water System’s Application for its 2026 General Rate Case, specifically materials associated with the Direct Testimony of Brian Deveraux. It is the position of Suburban Water Systems that confidential treatment is warranted pursuant to the statutory and regulatory authorities specified below.

3. I have personal knowledge of the facts and representations of fact stated in this Declaration and if called upon to testify could and would so competently, except such facts or representations as are stated to be based on upon information and belief, and as to those matters, I believe them to be true.

4. Listed below are the references to information and data for which Suburban Water Systems is seeking confidentiality protection and the basis for Suburban Water Systems’ confidentiality request

Location of Confidential Information	Description of Information that is Confidential	Basis for Confidentiality Claim
Direct Testimony of Brian Deveraux, Attachment 3 (entire document)	This attachment is a compilation of materials from Suburban Water Systems’ insurance providers providing summaries and projections of Suburban Water Systems’ healthcare insurance premium and benefit plan costs and features. Therefore, the public interest served by upholding confidentiality clearly outweighs the public interest in disclosure. The public disclosure	Cal. Govt. Code § 7922.000

Location of Confidential Information	Description of Information that is Confidential	Basis for Confidentiality Claim
	<p>of this information would undermine the ability of Suburban Water Systems to competitively seek and obtain insurance plans in the market by allowing other health insurance providers to strategically underbid the plans that Suburban Water Systems currently has. This would result in passing on such unnecessary costs in rates, thereby harming customers and the public. The public interest in disclosure of this information is minimal, as the California Public Utilities Commission can examine such confidential information to determine the reasonableness of the costs incurred by Suburban Water Systems without needing to publicly disclose such information. Therefore, the public interest served by upholding confidentiality clearly outweighs the public interest in disclosure.</p>	

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on January 2, 2026 at Pasadena, California.

/s/ Craig Gott _____

Craig Gott
 President
 Suburban Water Systems