**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.welcometouhc.com/uhcwest** or by calling **1-800-825-9355.**

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: **$0** Individual / **$0** Family | See the chart starting on page 2 for your costs for services this plan covers. |
| **Are there other deductibles for specific services?** | No | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | Yes, Network: **$1,500** Individual / **$3,000** Family | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premium, balance-billed charges, health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No, this policy has no overall annual limit on the amount it will pay each year. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of **network providers**, see www.welcometouhc.com/uhcwest or call 1-800-825-9355. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating to refer to **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | Yes, written or oral approval is required, based upon medical policies. | This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**. |
| **Are there services this plan doesn't cover?** | Yes | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call 1-800-825-9355 for Member Services or visit us at www.welcometouhc.com/uhcwest. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the telephone numbers above to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan only covers services if rendered by network **providers**. Exceptions include emergency services as described in your policy.

| Common Medical Event | Services You May Need | Your cost if you use a Network Provider | Your cost if you use a Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15 copay per visit | Not Covered | If you receive services in addition to office visit, additional copays or co-ins may apply. |
| | Specialist visit | $15 copay per visit | Not Covered | Member is required to obtain a referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services and Emergency / Urgently needed services. If you receive services in addition to office visit, additional copays or co-ins may apply. |
| | Other practitioner office visit | $15 copay per visit for Manipulative (Chiropractic) Treatment | Not Covered | Limited to 30 visits for Manipulative (Chiropractic) Treatment per Calendar year. |
| | Preventive care / screening / immunization | No Charge | Not Covered | Includes preventive health services specified in the health care reform law. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge | Not Covered | None |
| | Imaging (CT / PET scans, MRIs) | No Charge | Not Covered | None |

| Common Medical Event | Services You May Need | Your cost if you use a Network Provider | Your cost if you use a Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.welcometouhc.com/uhcwest. | Tier 1 – Your Lowest-Cost Option | Retail: $10 copay<br>Mail-Order: $20 copay | Not Covered | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 30 day supply.<br>Mail-Order: Up to a 90 day supply.<br>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.<br>Formulary Generic Contraceptives covered at No Charge.<br>You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.<br>See the website listed for information on drugs covered by your plan. Not all drugs are covered. |
| | Tier 2 – Your Midrange-Cost Option | Retail: $25 copay<br>Mail-Order: $50 copay | Not Covered | |
| | Tier 3 – Your Highest-Cost Option | Retail: $40 copay<br>Mail-Order: $80 copay | Not Covered | |
| | Tier 4 – Additional High-Cost Options | Not Applicable | Not Covered | |
| **If you have outpatient surgery** | Facility fee (example: ambulatory surgery center) | $50 copay per admit | Not Covered | None |
| | Physician / surgeon fees | No Charge | Not Covered | None |
| **If you need immediate medical attention** | Emergency room services | $50 copay per visit | $50 copay per visit | Copay waived if admitted. |
| | Emergency medical transportation | No Charge | No Charge | None |
| | Urgent care | $15 copay per visit | Not Covered | If you receive services in addition to urgent care, additional copays or co-ins may apply. |
| **If you have a hospital stay** | Facility fee (example: hospital room) | $100 copay per admit | Not Covered | None |
| | Physician / surgeon fees | No Charge | Not Covered | None |

| Common Medical Event | Services You May Need | Your cost if you use a Network Provider | Your cost if you use a Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental / Behavioral health outpatient services | $15 copay per visit | Not Covered | None |
| | Mental / Behavioral health inpatient services | $100 copay per admit | Not Covered | None |
| | Substance use disorder outpatient services | $15 copay per visit | Not Covered | None |
| | Substance use disorder inpatient services | $100 copay per admit | Not Covered | None |
| **If you are pregnant** | Prenatal and postnatal care | $15 copay per pregnancy | Not Covered | Additional copays or co-ins may apply depending on services rendered. Routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges. |
| | Delivery and all inpatient services | $100 copay per admit | Not Covered | Additional copays or co-ins may apply. Your cost for inpatient services only. Delivery see above. |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | Not Covered | None |
| | Rehabilitation services | $15 copay per visit | Not Covered | Coverage is limited to physical, occupational, and speech therapy. |
| | Habilitative services | Not Covered | Not Covered | No coverage for Habilitative services. |
| | Skilled nursing care | No Charge | Not Covered | Limited to 100 consecutive Inpatient days per disability. |
| | Durable medical equipment | No Charge | Not Covered | None |
| | Hospice service | None | Not Covered | If inpatient admission, subject to inpatient copays. |
| **If your child needs dental or eye care** | Eye exam | $15 copay per visit | Not Covered | 1 exam every 12 months. |
| | Glasses | Not Covered | Not Covered | None |
| | Dental check-up | Not Covered | Not Covered | No coverage for Dental check-ups. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

**Other Covered Services** **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-825-9355. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your human resource department or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or Oklahoma Department of Insurance at 1-800-522-0071 or http://www.ok.gov/oid/.

A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-825-9355.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-825-9355.
CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-800-825-9355.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-825-9355.

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

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays** $7,210
- **Patient pays** $330

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Co-pays | $130 |
| Co-insurance | $0 |
| Limits or exclusions | $200 |
| **Total** | **$330** |

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

- **Amount owed to providers: $5,400**
- **Plan pays** $4,360
- **Patient pays** $1,040

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment & Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Co-pays | $1,000 |
| Co-insurance | $0 |
| Limits or exclusions | $40 |
| **Total** | **$1,040** |

# Questions and answers about Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers.** If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✖ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✖ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-800-825-9355 for Member Services or visit us at www.welcometouhc.com/uhcwest. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the telephone numbers above to request a copy.