The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.welcometouhc.com/uhcwest or by calling 1-800-624-8822. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-624-8822 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	A deductible does not apply.	See the Common Medical Events chart below 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.
What is the out-of-pocket limit for this plan?	For participating providers $800 individual / $2,400 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?	Copayments for certain services, 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.welcometouhc.com/uhcwest or call 1-800-624-8822 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use a non-participating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your participating provider might use a non-participating provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, written or oral approval is required, based upon medical policies.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge / office visit and No charge / Virtual visits by a designated virtual participating provider	Not covered	If you receive services in addition to office visit, additional copayments or coinsurance may apply.
	Specialist visit	No charge	Not covered	Member is required to obtain a referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services, reproductive health care services within the Participating Medical Group and Emergency / Urgently needed services. If you receive services in addition to office visit, additional copayments or coinsurance may apply.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com or call 1-800-788-7871.	Generic Drugs	$5 copay / prescription	Not covered	You must use a Participating Pharmacy listed on the UFCW Participating Pharmacy Directory of the Southern California Drug Benefit Fund or no coverage. Limited to a 30-day supply (90-day supply for maintenance drugs in certain therapeutic classifications). If you purchase a brand drug when a generic drug is available, you pay the brand drug copay plus the difference in cost between the brand drug and the generic drug unless your doctor indicates "dispense as written." Mail order only available outside California. See the website listed or call 1-800-788-7871 for information on drugs covered by your plan. Not all drugs are covered.
	Brand Drugs	$5 copay / prescription if generic equivalent not available; $8 copay / prescription if generic equivalent available and doctor orders "dispense as written"	Not covered	
	Preventive Care Drugs (including FDA approved Contraceptives)	No charge	Not covered	You must use a Participating Pharmacy listed on the UFCW Participating Pharmacy Directory of the Southern California Drug Benefit Fund. You must have a prescription or no coverage. Coverage is for generic drugs only (or brand name if a generic is unavailable or medically inappropriate). Preventive Care Drugs are limited to aspirin, fluoride supplementation, folic acid, colon cancer screening prep products, tobacco cessation medications, statin preventive medication, breast cancer preventive medication (e.g., Tamoxifene), FDA-approved female contraceptives, and pre-exposure prophylaxis (PrEP) for persons at increased risk of HIV acquisition. Age and frequency limits apply.
	Injectable (Specialty) Drugs	20% coinsurance	Not covered	Preauthorization from Optum Rx is required or no coverage. Injectables prescribed by UHC physicians and provided by UHC are covered at 100% by UHC and are not covered under the Prescription Drug Plan. If injectable drugs are administered in a UHC physician's office, office visit Copayment/Coinsurance may also apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$35 copay / visit	$35 copay / visit	Copayment waived if admitted.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	No charge	$35 copay / visit	If you receive services in addition to urgent care, additional copayments or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	Must use an HMC provider or no coverage. To find HMC providers, see hmc.personaladvantage.com (Access Code: SCDBF) or call 1-866-268-2510. Preauthorization from HMC is required for ECT, psychological testing and neuropsychological testing. Care may include tests and services described elsewhere in the SBC (i.e., diagnostic test).
	Inpatient services	No charge	Not covered	Preauthorization from HMC is required for all inpatient services, except emergency hospitalization. To find HMC providers, see hmc.personaladvantage.com (Access Code: SCDBF) or call 1-866-268-2510. Inpatient services include detox, inpatient rehabilitation, residential treatment programs, intensive outpatient programs, and partial day hospitalization.
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to certain preventive services. Routine pre-natal care and first postnatal visit is covered at No charge. Depending on the type of services, additional copayments or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Limited to 100 visits per calendar year.
	Rehabilitation services	No charge	Not covered	Coverage is limited to physical, occupational, and speech therapy.
	Habilitative services	No charge	Not covered	Coverage is limited to physical, occupational, and speech therapy.
	Skilled nursing care	No charge	Not covered	Up to 100 days per benefit period.
	Durable medical equipment	No charge	Not covered	None
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	UHC: No charge Fund: No charge	UHC: Not covered Fund: No charge	UHC: None Fund: Maximum benefit of $135 per exam
	Children's glasses	UHC: Not covered Fund: No charge to allowed amount. You pay all charges above the allowed amount		Fund: Allowed amount of $135 per year is reduced by the cost of eye exams paid by the Fund. Pediatric vision benefits are for children up to 19 years.
	Children's dental check-up	UHC: Not covered Fund: You may elect coverage from the Indemnity Dental Plan or the United Concordia Dental HMO Plan.		Your dental coverage is not subject to health care reform.

Excluded services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult) - (available under separate Indemnity Dental Plan or United Concordia Dental HMO)
- Hearing aids – (Benefit is provided separately through the Trust Fund. Maximum benefit of $750 for each ear in a 12-month period).
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (Fund provides limited benefit of up to $120 per calendar year)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Routine eye care (Adult) - (Coverage for glasses and contacts is limited to Fund provided benefit of $135/year for exam, frame and Lenses).
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies are: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.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: your human resource department, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform

Additionally, a consumer assistance program may help you file your appeal. Contact Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.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 1-800-624-8822.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-8822.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-800-624-8822.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-8822.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of participating provider pre-natal care and a hospital delivery)

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

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	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

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

This EXAMPLE event includes services like:
Primary care physician office visit *(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	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$300**

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

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

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$40**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-624-8822.

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