



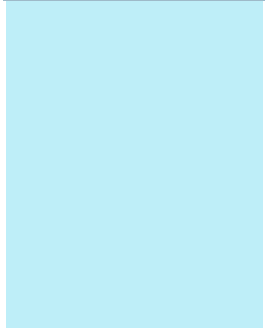
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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at welcometouhc.co	Tier 1 - Your Lowest Cost Option	Retail: \$10 copay deductible does not apply. Mail Order: \$20 copay deductible does not apply. Specialty Retail: 20% coinsurance with a \$300 maximum deductible does not apply	Retail: \$10 copay deductible does not apply. Specialty Retail: Not covered	<p><u>Provider means pharmacy</u> for purposes of this section.</p> <p>Retail: Up to a 30 day supply.</p> <p>Mail Order: Up to a 90 day supply or Preferred Day Retail Network Pharmacy. Specialty drugs are not covered through mail order.</p> <p>You may need to obtain certain drugs, including certain <u>specialty drugs</u> from a pharmacy designated by us. Certain drugs may have <u>preauthorization</u> requirement or may result in higher cost if you use an <u>out of network</u> pharmacy (including mail order pharmacy). You may be responsible for any amount over the <u>allowed amount</u>.</p> <p>Certain <u>preventive medication</u> (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a <u>covered</u> drug(s) prior to benefits under your policy being available for certain prescribed drugs.</p>
	Tier 2 - Your Mid Range Cost Option	Retail: \$30 copay deductible does not apply. Mail Order: \$60 copay deductible does not apply. Specialty Retail: 20% coinsurance with a \$300 maximum deductible does not apply	Retail: \$30 copay deductible does not apply. Specialty Retail: Not covered	
	Tier 3 - Your Mid Range Cost Option	Retail: \$60 copay deductible does not apply. Mail Order: \$120 copay deductible does not apply. Specialty Retail: 20% coinsurance with a \$300 maximum deductible does not apply	Retail: \$60 copay deductible does not apply. Specialty Retail: Not covered	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required <u>out of network</u> for certain services



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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan covers medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. For cost sharing amounts (deductibles, copayments, 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
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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 file a complaint with 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 60 days of the decision. 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) on any day 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 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 help, please call the number contained within this Summary of Benefits and Coverage (SBC) on any day 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。

重要通知：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，僅供成員在需要時使用。成員應根據其保險合約的條款和條件，向保險公司或承保人索取完整的福利和承保摘要(Summary of Benefits and Coverage, SBC)。

आपके लिए नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits) ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता

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