

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services



SignatureValue Harmony HMO
Gold 35-70/25%/1500ded

Coverage Period: Based on group plan year
Coverage for: Individual + Family | **Plan Type:** HMO

 **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.whyuhc.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?	\$1,500 /Individual or \$3,000 / family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care services, <u>specialist</u> visits, testing and tier 1 drugs are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes, Prescription drugs - \$100 Individual/ \$200 Family Does not apply to Tier 1 drugs. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	For participating <u>providers</u> \$7,600 Individual / \$15,200 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 <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, optional addenda, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.whyuhc.com/uhcwest or call 1-800-624-8822 for a list of <u>participating providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>non-participating provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>participating provider</u> might use an <u>non-participating provider</u> for some services (such as lab work). Check with your <u>provider</u> 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 <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 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
		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	\$35 copay / office visit, <u>deductible</u> does not apply and No Charge / Virtual visits by a designated virtual <u>participating provider</u> .	Not Covered	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply.
	<u>Specialist</u> visit	\$70 copay / visit, <u>deductible</u> does not apply	Not Covered	Member is required to obtain a <u>referral</u> to <u>specialist</u> or other licensed health care practitioner, except for OB/GYN Physician services, reproductive health care services within the <u>Participating Medical Group</u> and Emergency / Urgently needed services. If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductibles</u> or <u>coinsurance</u> may apply.
	<u>Preventive care/screening/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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab \$40 <u>copay</u> / test, <u>deductible</u> does not apply Radiology (Standard) \$40 <u>copay</u> / test, <u>deductible</u> does not apply	Not Covered	None
	<u>Imaging</u> (CT/PET scans, MRIs)	\$350 <u>copay</u> / test, <u>deductible</u> does not apply	Not Covered	None

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 <u>prescription drug coverage</u> is available at www.welcometouhc.uhcwest	Tier 1 - Your Lowest-Cost Option	Deductible does not apply. \$15 copay/ prescription retail \$30 copay/ prescription mail \$15 copay/ Specialty Drugs	Not Covered	Participating Provider means pharmacy for purposes of this section. Retail: Up to a 31-day supply. Mail-Order: Up to a 90 day supply. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. When applicable: Mail-Order Specialty drugs - Up to a 31 day supply. All limits are unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Copayment Maximum of \$250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan.
	Tier 2 - Your Midrange-Cost Option	\$50 copay/ prescription retail \$100 copay/ prescription mail \$150 copay/ Specialty Drugs	Not Covered	
	Tier 3 - Your Midrange-Cost Option	\$100 copay/ prescription retail \$200 copay/ prescription mail \$250 copay /Specialty Drugs	Not Covered	
	Tier 4 - Additional High-Cost Options	25% coinsurance / prescription retail up to \$250 copay per prescription. 25% coinsurance/ prescription mail order up to \$500 copay per prescription. 25% coinsurance/ Specialty Drugs up to \$250 copay per prescription.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	Not Covered	None
	Physician/surgeon fees	25% coinsurance, deductible does not apply	Not Covered	None
If you need immediate medical attention	Emergency room care	\$500 copay / visit	\$500 copay per visit	Copayment waived if admitted .
	Emergency medical transportation	\$100 copay / trip, deductible does not apply	\$100 copay per trip, deductible does not apply	None
	Urgent care	\$35 copay / office visit, deductible does not apply and	\$100 copay per visit, deductible does not apply	If you receive services in addition to urgent care visit, additional copays, deductibles, or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not Covered	None
	Physician/surgeon fees	25% coinsurance, deductible does not apply	Not Covered	None

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copay</u> / office visit, <u>deductible</u> does not apply No Charge for all other outpatient services;	Not Covered	Intensive Behavioral Therapy is covered at No charge
	Inpatient services	25% <u>coinsurance</u>	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Routine pre-natal care and first postnatal visit is covered at No charge.
	Childbirth/delivery professional services	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.
	Childbirth/delivery facility services	25% <u>coinsurance</u>	Not Covered	Depending on the type of services, additional <u>copayments</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	\$35 <u>copay</u> / visit, deductible does not apply	Not Covered	Limited to 100 visits per Calendar year. Limit does not apply to home health visits for rehabilitation and habilitation purposes.
	Rehabilitation services	\$35 <u>copay</u> / visit, <u>deductible</u> does not apply	Not Covered	None
	Habilitation services	\$35 <u>copay</u> / visit, <u>deductible</u> does not apply	Not Covered	None
	Skilled nursing care	25% <u>coinsurance</u>	Not Covered	Up to 100 days per benefit period.
	Durable medical equipment	\$70 <u>copay</u> / item, <u>deductible</u> does not apply	Not Covered	None
	Hospice services	No Charge	Not Covered	If inpatient admission, subject to inpatient <u>copayments</u> , <u>deductibles</u> or <u>coinsurance</u> .
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	1 exam per year .
	Children's glasses	25% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	One pair every 12 months.
	Children's dental check-up	No Charge	Not Covered	Cleanings covered 2 times per 12 months. Additional limitations may apply.

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.)

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| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Infertility treatment | • Private-duty nursing | |

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

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| • Acupuncture | • Chiropractic care | • Routine eye care (Adult) |
| • Bariatric surgery | • Hearing aids | |

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 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 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 1-800-782-3740.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-782-3740.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-782-3740.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-782-3740 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-782-3740.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-782-3740.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-800-782-3740.

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	\$1,500
■ Specialist copayment	\$70
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$400
Coinsurance	\$2,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,060

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$70
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$700

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$70
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,100
Copayments	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

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