




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.uhcwest.com or by calling 1-800-624-8822.

| Important Questions | Answers | Why This Matters: |
|--|---|--|
| What is the overall deductible? | Participating: \$0 Individual/ \$0 Family | See the chart starting on page 2 for your other costs for services this plan covers. |
| Are there other deductibles for specific services? | No, there are no other deductibles. | 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? | Participating: \$1,000 Individual / \$3,000 Family | The out-of-pocket limit is the most you could pay during a policy period 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, and prescription drugs. | 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 insurer 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 insurer will pay for <i>specific</i> covered services, such as office visits. |
| Does this plan use a network of providers? | Yes, this plan uses participating providers. If you use a non-participating provider your cost may be more. For a list of participating providers, see www.uhcwest.com or call 1-800-624-8822 for a list of participating providers. | If you use a participating doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your participating doctor or hospital may use a non-participating 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 | This plan will pay some or all of the costs to see a specialist but only if you have the plan's permission before you see the specialist for covered services. |
| 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 1-800-624-8822 for Member Services or visit us at www.uhcwest.com. If you aren't clear about any of the bolded 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.

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- **Co-payments (copays)** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
 - **Co-insurance (co-ins)** 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 a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating 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 participating providers. Exceptions include emergency services as described in your policy.

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|--|--|------------------------|----------------------------|---|
| | | Participating Provider | Non-participating Provider | |
| 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, deductibles 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, deductibles or co-ins may apply. |
| | Other practitioner office visit | Not Covered | Not Covered | No coverage for Manipulative (Chiropractic) Treatment. |
| | Preventive care / screening / immunization | \$15 copay per visit | Not Covered | |
| 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 | | Limitations & Exceptions |
|---|---|--|----------------------------|--|
| | | Participating Provider | Non-participating Provider | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.uhcwest.com | Tier 1 – Your Lowest-Cost Option | Retail: \$10 copay Mail-Order: \$20 copay | Not Covered | Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. 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. Not all drugs are covered. |
| | Tier 2 – Your Midrange-Cost Option | Retail: \$30 copay Mail-Order: \$60 copay | Not Covered | |
| | Tier 3 – Your Highest-Cost Option | Not Applicable | Not Applicable | |
| | Tier 4 – Additional High-Cost Options | Not Applicable | Not Applicable | |
| If you have outpatient surgery | Facility fee (example, ambulatory surgery center) | \$50 copay | Not Covered | None |
| | Physician / surgeon fees | No Charge | Not Covered | None |
| If you need immediate medical attention | Emergency room services | \$100 copay per visit | \$100 copay per visit | Copay waived if admitted. |
| | Emergency medical transportation | No Charge | No Charge | None |
| | Urgent care | \$15 copay per visit | \$100 copay per visit | Copay waived if admitted. If you receive services in addition to urgent care, additional copays, deductibles 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 | | Limitations & Exceptions |
|--|--|------------------------|----------------------------|---|
| | | Participating Provider | Non-participating Provider | |
| 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 | No Charge | Not Covered | Additional copays, deductibles or co-ins may apply. Routine pre-natal care is covered at No Charge. |
| | Delivery and all inpatient services | \$100 copay per admit | Not Covered | Additional copays, deductibles or co-ins may apply. |
| 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. |
| | Habilitation services | Not Covered | Not Covered | No coverage for Habilitation services. |
| | Skilled nursing care | \$100 copay | Not Covered | Limited to 100 consecutive calendar days from the first treatment per disability. |
| | Durable medical equipment | No Charge | Not Covered | Limited to \$5,000 Benefit Maximum per Calendar year. |
| | Hospice service | \$100 copay per admit | Not Covered | None |
| 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.) | | |
|--|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Chiropractic care • Cosmetic Surgery • Dental Care (Adult/Child) • Glasses – may be covered with limitations | <ul style="list-style-type: none"> • Habilitative Treatment • Infertility Treatment - may be covered with limitations • Long-term care • Non-emergency care when traveling outside the U.S | <ul style="list-style-type: none"> • 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.) | | |
|---|--|--|
| <ul style="list-style-type: none"> • Bariatric Surgery | <ul style="list-style-type: none"> • Hearing Aids – may be covered with limitations | <ul style="list-style-type: none"> • Routine eye care (Adult) – may be covered with limitations |

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 1-800-624-8822. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit <http://www.dol.gov/ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323x1565 or visit <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 visit www.dol.gov/ebsa/healthreform or Department of Managed Health Care at 1-888-466-2219 or visit <http://www.healthhelp.ca.gov>

Additionally, a consumer assistance program may help you file your appeal. Contact California Department of Managed Health Care Help Center at 1-888-466-2219 or visit <http://www.healthhelp.ca.gov>. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/prgrams/consumer/capgrants/index.html>.

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.

若需要中文协助，请拨打您会员卡上的电话号码

Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniye nanitinigii number bikaa'igii bich'i' hodiilnih

Para sa tulong sa Tagalog, tawagan ang numero sa iyong ID card.

-----*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 \$7,240
- Patient pays \$300

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 | \$100 |
| Co-insurance | \$0 |
| Limits or exclusions | \$200 |
| Total | \$300 |

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

- Amount owed to providers: \$5,400
- Plan pays \$4,420
- Patient pays \$980

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 | \$900 |
| Co-insurance | \$0 |
| Limits or exclusions | \$80 |
| Total | \$980 |

Questions and answers about Coverage Examples:

| | | |
|--|--|---|
| <p>What are some of the assumptions behind the Coverage Examples?</p> <ul style="list-style-type: none"> • 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-participating providers. If the patient had received care from out-of-participating providers, costs would have been higher. | <p>What does a Coverage Example show?</p> <p>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.</p> | <p>Can I use Coverage Examples to compare plans?</p> <p>✓ 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</p> |
| | <p>Does the Coverage Example predict my own care needs?</p> <p>✗ 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.</p> | <p>Are there other costs I should consider when comparing plans?</p> <p>✓ 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.</p> |
| | <p>Does the Coverage Example predict my future expenses?</p> <p>✗ 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.</p> | |

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