



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 welcometouhc.com or by calling 1-888-383-0132.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes, Prescription drugs - \$50 per person, for Tier 2 and 3. There are no other specific deductibles .	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Network: \$4,500 Individual / \$8,000 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, and 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.	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 welcometouhc.com/nexus1 or call 1-888-383-0132.	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 for 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. An electronic referral is required to see a Network Specialist .	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 1-888-383-0132 or visit us at welcometouhc.com/nexus1. If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-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 may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider with Referral	Your Cost If You Use a Network Provider without Referral	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Tier 1:\$10 copay per visit Network: \$25 copay per visit	Not Covered	Not Covered	Primary care provider (PCP) must be assigned. No referral required for OB/GYN. Virtual visits (Telehealth) – \$10 copay per visit by a designated virtual network provider. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	Tier 1: \$35 copay per visit Network:\$55 copay per visit	Not Covered	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	\$45 copay per visit	Not Covered	Not Covered	Cost share applies for only manipulative (chiropractic) services and is limited to 20 visits per calendar year.
	Preventive care / screening / immunization	No Charge	Not Covered	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	No Charge	Not Covered	None
	Imaging (CT / PET scans, MRIs)	\$150 copay	\$150 copay	Not Covered	None

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider with Referral	Your Cost If You Use a Network Provider without Referral	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at myuhc.com	Tier 1 – Your Lowest-Cost Option	Retail: \$10 copay Mail-Order: \$30 copay	Retail: \$10 copay Mail-Order: \$30 copay	Not Covered	Provider means pharmacy for purposes of this section.
	Tier 2 – Your Midrange-Cost Option	Retail: \$35 copay or 20% of the cost with a \$70 maximum copay Mail-Order: \$105 copay or 20% of the cost with a \$210 maximum copay	Retail: \$35 copay or 20% of the cost with a \$70 maximum copay Mail-Order: \$105 copay or 20% of the cost with a \$210 maximum copay	Not Covered	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. Certain drugs may have a pre-authorization requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you are responsible for any amount over the allowed amount.
	Tier 3 and Specialty Drugs – Your Highest-Cost Option	Retail: \$55 copay or 20% of the cost with a \$110 maximum copay Mail-Order: \$165 copay or 20% of the cost with a \$330 maximum copay	Retail: \$55 copay or 20% of the cost with a \$110 maximum copay Mail-Order: \$165 copay or 20% of the cost with a \$330 maximum copay	Not Covered	You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Pharmacy deductible does not apply to Tier 1.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier 1: \$750 copay per visit Network:\$1,000 copay per visit	Not Covered	Not Covered	Primary care provider (PCP) must be assigned. No referral required for OB/GYN.
	Physician / surgeon fees	No Charge	Not Covered	Not Covered	Primary care provider (PCP) must be assigned. No referral required for OB/GYN.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider with Referral	Your Cost If You Use a Network Provider without Referral	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	\$250 copay per visit	\$250 copay per visit	\$250 copay per visit	None
	Emergency medical transportation	\$200 copay per transport	\$200 copay per transport	\$200 copay per transport	None
	Urgent care	\$45 copay per visit	\$45 copay per visit	Not Covered	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 (e.g., hospital room)	Tier 1: \$1,500 copay perinpatient stay Network: \$2,500 copay perinpatient stay	Not Covered	Not Covered	None
	Physician / surgeon fees	No Charge	Not Covered	Not Covered	Primary care provider (PCP) must be assigned. No referral required for OB/GYN.
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	\$10 copay per visit	\$10 copay per visit	Not Covered	None
	Mental / Behavioral health inpatient services	\$1,500 copay per inpatient stay	\$1,500 copay per inpatient stay	Not Covered	None
	Substance use disorder outpatient services	\$10 copay per visit	\$10 copay per visit	Not Covered	None
	Substance use disorder inpatient services	\$1,500 copay per inpatient stay	\$1,500 copay per inpatient stay	Not Covered	None
If you are pregnant	Prenatal and postnatal care	\$25 copay first visit	No Charge	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	Tier 1:\$1,500 copay per inpatient stay Network:\$2,500 copay perinpatient stay	Not Covered	Not Covered	Your cost for inpatient services only. Delivery Services cost share is reflected in "Physician/surgeon fees" above.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider with Referral	Your Cost If You Use a Network Provider without Referral	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	\$30 copay per visit	\$30 copay per visit	Not Covered	Limited to 120 visits per calendar year.
	Rehabilitation services	\$45 copay per outpatient visit	\$45 copay per outpatient visit	Not Covered	Outpatient rehabilitation services are unlimited per calendar year.
	Habilitative services	\$45 copay per outpatient visit	\$45 copay per outpatient visit	Not Covered	Limits are combined with Rehabilitation Services limits listed above.
	Skilled nursing care	\$25 copay per day	\$25 copay per day	Not Covered	Benefits are limited as follows: Inpatient: Unlimited Outpatient: 30 days per year (combined with inpatient rehabilitation)
	Durable medical equipment	No charge, plan pays 100%	No charge, plan pays 100%	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice service	No Charge	No Charge	Not Covered	None
If your child needs dental or eye care	Eye exam	\$45 copay	\$45 copay	Not Covered	Limited to 1 exam every year.
	Glasses	Not Covered	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	Not Covered	No coverage for dental check-up

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
- Cosmetic surgery
- Dental care (Adult/Child)
- Glasses (Adult/Child)
- Infertility treatment
- 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.)

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|---------------------|----------------|----------------------------------|
| • Chiropractic care | • Hearing aids | • Routine eye care (Adult/Child) |
|---------------------|----------------|----------------------------------|

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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 the Member Service number listed on the back of your ID card or myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

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 1-800-430-7316.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-430-7316.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-800-430-7316.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-430-7316.

-----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 will also 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 \$5,840
- Patient pays \$1,700

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
Copays (Tier 1)	\$1,500
Coinsurance	\$0
Limits or exclusions	\$200

Total \$1,700

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,310
- Patient pays \$1,090

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100

Total \$5,400

Patient pays:

Deductibles	\$50
Copays	\$700
Coinsurance	\$300
Limits or exclusions	\$40

Total \$1,090

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-network providers. If the patient had received care from out-of-network providers, costs would have been higher. • If other than individual coverage, the Patient Pays amount may be more. 	<p>What does a Coverage Example show?</p> <p>For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance 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 copayments, deductibles, and coinsurance. 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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