



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/alameda 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 <u>deductible</u>?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> and primary care services 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For <u>participating providers</u> \$1,500 individual / \$3,000 family.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u>?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, 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 <u>network provider</u>?	Yes. See www.welcometouhc.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 a <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 a <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 <u>referral</u> to see a <u>specialist</u>?	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> .

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	\$15 <u>copay</u> / office visit and \$15 <u>copay</u> / Virtual visits by a designated virtual <u>participating provider</u>	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> or <u>coinsurance</u> may apply.
	Specialist visit	\$15 <u>copay</u> / visit	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 <u>Physician services</u> , 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> or <u>coinsurance</u> may apply.
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> 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.welcometouhc.com/uhcwest .	Tier 1	\$10 <u>copay</u> / prescription retail \$20 <u>copay</u> / prescription mail order	Not covered	<u>Participating Provider</u> 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 <u>specialty drugs</u> , from a pharmacy designated by us. Mail-Order <u>Specialty Drugs</u> : Up to a 31 day supply. All limits are unless adjusted based on the drug manufacture's packaging size, or based on supply limits. Certain preventive medications (including certain contraceptives) are covered at No charge. 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 <u>plan</u> .
	Tier 2	\$25 <u>copay</u> / prescription retail \$50 <u>copay</u> / prescription mail order	Not covered	
	Tier 3	\$35 <u>copay</u> / prescription retail \$70 <u>copay</u> / prescription mail order	Not covered	
	Tier 4	Not applicable	Not covered	
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	\$50 <u>copay</u> / visit	\$50 <u>copay</u> / visit	<u>Copayment</u> waived if admitted.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	\$15 <u>copay</u> / visit	\$50 <u>copay</u> / visit	If you receive services in addition to <u>urgent care</u> , additional <u>copayments</u> or <u>coinsurance</u> 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	

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	\$15 <u>copay</u> / office visit and No charge for all other outpatient services	Not covered	Substance abuse outpatient services are covered at No charge.
	Inpatient services	No charge	Not covered	
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. 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).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
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	\$15 <u>copay</u> / visit	Not covered	Coverage is limited to physical, occupational, and speech therapy.
	Habilitative services	\$15 <u>copay</u> / visit	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	
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay</u> / visit	Not covered	1 exam per year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	No coverage for Dental check-ups.

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](#).)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)
- Weight loss programs – Real Appeal

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, kwijigo 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](#) \$15
- Hospital (facility) [copayment](#) \$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](#) \$15
- Hospital (facility) [copayment](#) \$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	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$800

Mia's Simple Fracture

([participating provider emergency room](#) visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$15
- Hospital (facility) [copayment](#) \$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	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$100

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.

English

IMPORTANT LANGUAGE INFORMATION:

You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at UnitedHealthcare of California 1-800-624-8822 / TTY: 711. If you need more help, call DMHC Help Line at 1-888-466-2219.

Spanish

INFORMACIÓN IMPORTANTE SOBRE IDIOMAS:

Es probable que usted disponga de los derechos y servicios a continuación. Puede pedir un intérprete o servicios de traducción sin cargo. Es posible que tenga disponible documentación impresa en algunos idiomas sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud de UnitedHealthcare of California al 1-800-624-8822 / TTY: 711. Si necesita más ayuda, llame a la Línea de Ayuda de la DMHC al 1-888-466-2219.

Chinese

您可能 :

您可能有权利和服务如下。您可以免费获得口译或翻译服务。某些语言的文件可能也有提供。为了获得您语言方面的帮助，请致电您的健康计划，致电加州联合健康保险 1-800-624-8822 / 电话：711。如果您需要更多帮助，请拨打 DMHC 帮助热线 1-888-466-2219。

Arabic

قد تكون مؤهلة للحصول على الحقوق والخدمات أدناه. يمكنك الحصول على خدمات الترجمة أو التفسير مجاناً. قد تكون متاحة بعض المعلومات المكتوبة بلغة أخرى مجاناً. للحصول على المساعدة بلغة لغتك، يرجى الاتصال بخطة التأمين الصحية في كاليفورنيا على الرقم 1-800-624-8822 / تليفون: 711. إذا كنت بحاجة إلى مزيد من المساعدة، يرجى الاتصال بخط مساعدة DMHC على الرقم 1-888-466-2219.

Armenian

Կարող եք լինել իրավունքների և ծախսերի սեփականատեր: Կարող եք ստանալ թարգմանչի կամ լեզուների խոսակցի օգնությունը առանց վճարելու: Կարող եք ստանալ տպագրված տեղեկություններ որոշ լեզուներով առանց վճարելու: Կարող եք ստանալ օգնություն ձեր լեզվով: Կապվե՛ք Ձեր առողջապահության պլանի հետ կապված 1-800-624-8822 / ԹԿԿ: 711 համարով: Եթե ավելի օգնություն է պահանջում, կապվե՛ք DMHC-ի հետ 1-888-466-2219 համարով:

Cambodian

អ្នកអាចមានសិទ្ធិ និងសេវាខាងក្រោម។ អ្នកអាចទទួលបានសេវាបកប្រែ ឬសេវាបកប្រែភាសាដទៃទៀត ដោយឥតគិតថ្លៃ។ ព័ត៌មានលម្អិតអាចមានស្រាប់ ក្នុងភាសាខ្លះៗ ដោយឥតគិតថ្លៃ។ ដើម្បីទទួលបានជំនួយ ឬព័ត៌មានបន្ថែម ក្នុងភាសាខ្មែរ ឬភាសាដទៃទៀត ទូរស័ព្ទលេខ 1-800-624-8822 / តេឡិទ្រាម: 711 ។ ប្រសិនបើអ្នកត្រូវការជំនួយបន្ថែម ទូរស័ព្ទលេខ 1-888-466-2219 ។

Farsi

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Hmong

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Japanese

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Russian

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Tagalog

MAHALAGANGIMPORMASYONSAWIK A :
Maaaring kwalipikado ka sa mga karapatan at serbisyo sa ibaba. Maaari kang kumuha ng
interpreter o mga serbisyo sa pagsasalín nang walang bayad . Maaaring may available ding libreng
nakasulat na impormasyon sa ilang wika. Upang makatanggap ng tulong sa iyong wika,
mangyaring tumawag sa iyong planong pangkalusugan sa: UnitedHealthcare of California
1-800 -624 - 88 22 / TTY: 711 . Kung kailangan mo ng higit pang tulong, tumawag sa DMHC
Help Line sa 1-888-466-2219.

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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 30 days. 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 phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m.

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Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint forms are available at <http://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