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 uhc.com/employer/small-business/shop/dc or by calling 1-877-856-2430. 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.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $1,000 Individual / $2,000 Family out-of-Network: $2,000 Individual / $4,000 Family Per policy year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, Dental Deductible: Network: $50 Individual/ $100 Family There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: $5,000 Individual / $10,000 Family out-of-Network: $10,000 Individual / $20,000 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 plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See uhc.com/find-a-physician/shopdcchoiceplus or call 1-877-856-2430 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Network Provider (You will pay the least)	Out-of-Network 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	$25 copay per visit, deductible does not apply	30% coinsurance	Virtual visits (Telehealth) - $10 copay per visit by a Designated Virtual Network Provider, deductible does not apply. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Specialist visit	$50 copay per visit, deductible does not apply	30% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/immunization	No Charge	30% coinsurance	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing/Office: $50 copay per visit Hospital: $50 copay per visit	30% coinsurance	Preauthorization required for out-of-Network for certain services or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: 0% coinsurance Hospital: 0% coinsurance	30% coinsurance	$250 Hospital-Based per occurrence deductible applies prior to the overall deductible. Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.

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 **prescription drug coverage** is available at uhc.com/rxfind	Tier 1 - Your Lowest-Cost Option	Deductible does not apply. Retail: $10 copay Mail-Order: $25 copay Specialty Drugs: $10 copay	Deductible does not apply. Retail: $10 copay Specialty Drugs: $10 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. If you use an out-of-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. 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. Certain drugs may have a preauthorization requirement or may result in a higher cost. 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. If a dispensed drug has a chemically equivalent drug, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Deductible does not apply. Retail: $40 copay Mail-Order: $100 copay Specialty Drugs: $120 copay	Deductible does not apply. Retail: $40 copay Specialty Drugs: $120 copay	
	Tier 3 - Your Midrange-Cost Option	Deductible does not apply. Retail: $75 copay Mail-Order: $187.50 copay Specialty Drugs: $150 copay	Deductible does not apply. Retail: $75 copay Specialty Drugs: $150 copay	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center: 0% coinsurance Hospital: 0% coinsurance	30% coinsurance	Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed. $250 Hospital per occurrence deductible applies prior to the overall deductible.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	$100 Emergency per occurrence deductible applies prior to the overall deductible.

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)	
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	$25 copay per visit, deductible does not apply	30% coinsurance	If you receive services in addition to urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay per visit, deductible does not apply	30% coinsurance	Network partial hospitalization /intensive patient treatment: 0% coinsurance Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.
	Inpatient services	0% coinsurance	30% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	Inpatient preauthorization apply for out-of-Network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	Limited to 90 visits up to 4 hours per visit per "episode of care". Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Rehabilitation services	$25 copay per outpatient visit, deductible does not apply	30% coinsurance	Limits per policy year: Physical, Speech, Occupational, Pulmonary: Unlimited. Cardiac: 90 visits. Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.

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)	
	Habilitation services	$25 copay per outpatient visit, deductible does not apply	30% coinsurance	Limits per policy year: Physical, Speech, Occupational: Unlimited. Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.
	Skilled nursing care	0% coinsurance	30% coinsurance	Skilled nursing is limited to 60 days per policy year. (Inpatient Rehabilitation and Habilitation limited to 90 days each). Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Durable medical equipment	0% coinsurance	30% coinsurance	Covers 1 per type of Durable medical equipment (including repair/replace) every 2 years. Preauthorization required for out-of-Network Durable medical equipment over $1,000 or no coverage.
	Hospice services	0% coinsurance	30% coinsurance	Preauthorization required for out-of-Network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam	$25 copay per visit, deductible does not apply	50% coinsurance	One exam every 12 months.
	Children's glasses	50% coinsurance, deductible does not apply	50% coinsurance	One pair every 12 months.
	Children's dental check-up	0% coinsurance	0% coinsurance	Cleanings covered 2 times per 12 months.

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.)				
• Bariatric Surgery	• Cosmetic Surgery	• Dental Care (Adult)	• Infertility Treatment	• Long-Term Care
• Non-emergency care when traveling outside the U.S.	• Private-Duty Nursing	• Routine Eye Care (Adult)	• Routine Foot Care	• Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture - Anesthesia only	• Chiropractic care	• Hearing Aids - $2,500/ policy year

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 is: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration, or 1-877-267-2323 x61565 or www.cciio.cms.gov for the U.S. Department of Health and Human Services. You may also contact us at 1-877-856-2430 . 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 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: 1-877-856-2430 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the District of Columbia Department of Insurance, Securities, and Banking at 202-727-8000 or disr.washingtondc.gov/disr/site. Additionally, a consumer assistance program can help you file your appeal. Contact DC Office of the Health Care Ombudsman and Bill of Rights at 1-877-685-6391 or visit healthcareombudsman@dc.gov.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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 1-877-856-2430 .
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-856-2430 .
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-856-2430 .
Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-877-856-2430 .

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 in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $ 1,000
- **Specialist copayment** $50
- **Hospital (facility) coinsurance** 0%
- **Other coinsurance** 0%

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	$12,800
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,260

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $ 1,000
- **Specialist copayment** $50
- **Hospital (facility) coinsurance** 0%
- **Other coinsurance** 0%

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	$7,400
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$1,630

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $ 1,000
- **Specialist copayment** $50
- **Hospital (facility) coinsurance** 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	$1,900
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,000

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

Notice of Non-Discrimination

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 send a complaint to 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 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 number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday 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 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

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

If you, or someone you're helping, has questions about the Health Insurance Marketplace, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-856-2430.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Health Insurance Marketplace, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-856-2430.

እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Health Insurance Marketplace ጥያቄ ካላቸሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-877-856-2430 ይደውሉ።

如果您，或是您正在協助的對象，有關於Health Insurance Marketplace 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話1-877-856-2430。

Si vous, ou une personne que vous aidez, avez des questions à propos du Health Insurance Marketplace, vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour parler à un interprète, appelez le 1-877-856-2430.

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Health Insurance Marketplace, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makipag-usap sa isang tagasalin ng wika, tumawag sa 1-877-856-2430.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Health Insurance Marketplace, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-856-2430.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Health Insurance Marketplace, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-856-2430.

Se tu o qualcuno che stai aiutando avete domande su Health Insurance Marketplace, avete il diritto di ottenere aiuto e informazioni nella vostra lingua gratuitamente. Per parlare con un interprete, potete chiamare 1-877-856-2430.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Health Insurance Marketplace, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-856-2430.

I bale we, tole mut u ye hola, a gwee mbarga inyu Health Insurance Marketplace, U gwee Kunde I kosna mahola ni biniiguene i hop wong nni nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-877-856-2430.

Ọ bụrụ gị, ma o bụ onye I na eyere-aka, nwere ajụjụ gbasara Health Insurance Marketplace, I nwere ohere iwenta nye maka na ọmụma na asụsụ gị na akwughi ụgwọ. I chọrọ I kwụrụ onye-ntapịa okwu, kpọ 1-877-856-2430.

Bí ìwọ, tàbí ẹnikẹni tí o n ranlọwọ, bá ní ibeere nípa Health Insurance Marketplace, o ní ẹtọ lati gba iranwọ àti ifitónilétí ní èdè rẹ láìsanwó. Láti bá ongbufọ kan sọrọ, pè sórí 1-877-856-2430.

যদি আপনি, অথবা আপনি অন্য কাউকে সহায়তা করছেন, তাদের Health Insurance Marketplace সম্পর্কে প্রশ্ন থাকলে, আপনার অধিকার আছে বিনা খরচে সাহায্য পাবার , এবং আপনার নিজস্ব ভাষাতে তথ্য জানবার। অনুবাদকের সাথে কথা বলার জন্য, কল করুন 1-877-856-2430.

ご本人様、またはお客様の身の回りの方でも、Health Insurance Marketplace についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-877-856-2430までお電話ください。

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Health Insurance Marketplace에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-877-856-2430로 전화하십시오.

หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Health Insurance Marketplace คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลเป็นภาษาของคุณได้โดยไม่ต้องเสียค่าใช้จ่ายใดๆ พูดคุยกับล่าม โทรฯ 1-877-856-2430

Falls Sie oder jemand, dem Sie helfen, Fragen zum Health Insurance Marketplace haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-856-2430 an.

إذا كان لديك أو لدى شخص تساعده أسئلة بخصوص Health Insurance Marketplace، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أي تكلفة. للتحدث مع مترجم اتصل بـ 1-877-856-2430.