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.uhc.com/calpers or by calling 1-877-359-3714. 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 1-877-359-3714 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care and primary care services are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For participating providers $1,500 individual / $3,000 family. $6,650 individual / $13,300 family (Prescription Drugs)</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.uhc.com/calpers">www.uhc.com/calpers</a> or call 1-877-359-3714 for a list of participating providers.</td>
<td>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 a non-participating 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 participating provider might use a non-participating provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes. There may be some providers or services for which referrals are not required.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Participating Provider (You will pay the least)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 <strong>copay</strong> / office visit and $15 <strong>copay</strong> / Virtual visits by a designated virtual participating provider</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$15 <strong>copay</strong> / visit</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
</tr>
</tbody>
</table>
### Common Medical Event

**If you need drugs to treat your illness or condition**

More information about [prescription drug coverage](https://www.optumrx.com/calpers) is available at [www.optumrx.com/calpers](https://www.optumrx.com/calpers) or (855) 505-8110.

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 – Generic drugs</td>
<td>$5 copay / prescription retail $10 copay / prescription mail order</td>
<td>Not covered</td>
<td>Participating Provider means pharmacy for purposes of this section. Retail: Up to a 30 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 OptumRx. 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 plan.</td>
</tr>
<tr>
<td>Tier 2 – Preferred Brand drugs</td>
<td>$20 copay / prescription retail $40 copay / prescription mail order</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Tier 3 – Non-Preferred Brand drugs</td>
<td>$50 copay / prescription retail $100 copay / prescription mail order</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Tier 4 – Specialty drugs</td>
<td>Not applicable</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

**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 copay / visit | $50 copay / visit | Copayment waived if admitted.

**Emergency medical transportation**

No charge | No charge | None

**Urgent care**

$15 copay / visit | $15 copay / visit | If you receive services in addition to urgent care, additional copayments or coinsurance 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 |
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$15 copay / office visit and No charge for all other outpatient services</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
<td>Cost sharing does not apply to certain preventive services. Routine pre-natal care and first postnatal visit is covered at No charge. Depending on the type of services, additional copayments or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15 copay / visit</td>
<td>Not covered</td>
<td>Coverage is limited to physical, occupational, and speech therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitative services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>No coverage for Habilitative services.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
<td>Up to 100 days per benefit period.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>Not covered</td>
<td>1 exam per year.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>No coverage for Dental check-ups.</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Dental care (Child)</td>
</tr>
</tbody>
</table>

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

| ▪ Acupuncture | ▪ Hearing aids | ▪ Routine eye care (Adult) |
| ▪ Bariatric surgery | ▪ Infertility treatment | ▪ Weight loss programs |
| ▪ Chiropractic care | | |
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 http://www.healthhelp.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 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 http://www.healthhelp.ca.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 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, kwiijigo 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of participating provider pre-natal care and a hospital delivery)</td>
<td>(a year of routine participating provider care of a well-controlled condition)</td>
<td>(participating provider emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

- **The plan’s overall deductible**
  - Peg: $0
  - Joe: $0
  - Mia: $0
- **Specialist copayment**
  - Peg: $15
  - Joe: $15
  - Mia: $15
- **Hospital (facility) copayment**
  - Peg: $0
  - Joe: $0
  - Mia: $0
- **Other coinsurance**
  - Peg: 0%
  - Joe: 0%
  - Mia: 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**

- Peg: $12,800
- Joe: $7,400
- Mia: $1,900

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Peg</th>
<th>Joe</th>
<th>Mia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$20</td>
<td>$700</td>
<td>$100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60
- The total Peg would pay is: $80
- Limits or exclusions: $30
- The total Joe would pay is: $730
- 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: 1-877-359-3714.

The plan would be responsible for the other costs of these EXAMPLE covered services.
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 HMO Help Line at 1-888-466-2219.

Spanish
INFORMACIÓN IMPORTANTE SOBRE IDIOMAS:
Es posible 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 HMO al 1-888-466-2219.

Chinese
重要语言资讯：
您可能有资格享有下列权利并取得下列服务。您可以免费获取口译员或翻译服务。部分语言亦备有免费书面资讯。如需取得您语言的协助，请拨打下列电话与您的健保计画联络：UnitedHealthcare of California 1-800-624-8822 / 聆力语言残障服务专线（TTY）：711。若您需要更多协助，请拨打 HMO 协助专线 1-888-466-2219。

Arabic
معلومات مهمة عن اللغة:
ربما تكون مؤهلًا للحصول على الحقوق والخدمات أدناه. يمكنك الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. وربما تكون أيضا المعلومات المكتوبة بعدها لغات بدون رسوم. واللحصول على مساعدة بلغتك، يرجى الاتصال بخط المساعدة على: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. إذا احتاجت لمزيد من المساعدة، يرجى الاتصال على الرقم 1-888-466-2219 من HMO.

Armenian
Երանոցի լեզուների տեղեկատույք:
Ձեզ կհաջնեք սահմանված իրավունքները և ծառայությունները, եթե հասնությունը կհանձնի անցումը ամրապնդակագիր: UnitedHealthcare of California 1-800-624-8822 / TTY: 711 հեռախոսից: մեկնուն լեզուների փաստաթղթերով, անգլերեն HMO-ի Օգտագործման համակարգում 1-888-466-2219 հեռախոսից:

Cambodian
ប្រការព័ត៌មានអំពូលភាសា:
ប្រសិនបើក្លាហ្វុក្លាតឬក្លាការសិទ្ធិរបស់អ្នកគឺជាប្រការព័ត៌មានអំពូលភាសាអន្តរជាតិនិងសំឡេងដ៏ល្អិត។ UnitedHealthcare of California 1-800-624-8822 / TTY: 711 ការសិទ្ធិរបស់អ្នកអាចដល់តាមរយៈជំនួសសេវានីមួយៗ ឬប្រការព័ត៌មានអំពូលភាសា។
Farsi
اطلاعات مهم در مورد زبان:
شما ممکن است برای حقوق و خدمات زیر واحد شرایط بانی می‌باشید. سی توئیند خدمات مترجم شفاهی یا ترجمه را بدون پرداخت هزینه دریافت کنید. اطلاعات کنی ممکن است بدون پرداخت هزینه به بری زبان ها موجود باشد. برای دریافت کمک و راهنمایی به زبان خودتان، لطفا با برنامه درمانی: 1-800-624-8822 / TTY: 711. تاس-بیگرید. اگر به کمک و راهنمایی پیشتر نیاز دارید، با خط دریافت کمک و راهنمایی UnitedHealthcare of California 1-888-466-2219.

Hindi
भाषा-संबंधी महत्वपूर्ण जानकारी:
आप लिखित अधिकारों और सेवाओं के हकदर्म हो सकते हैं। आपको मुफ्त में दुःखित या अनुदान सेवाएँ उपलब्ध कराई जा सकती हैं। कुछ भाषाओं में लिखित जानकारी भी आपको मुफ्त में उपलब्ध कराई जा सकती हैं। अपनी भाषा में सहायता प्राप्त करने के लिए, कृपया अपने स्वास्थ्य प्लान को यहां कॉल करें: UnitedHealthcare of California 1-800-624-8822 / TTY: 711। अतिरिक्त सहायता की आवश्यकता पड़ने पर, HMO Help Line को 1-888-466-2219 पर कॉल करें।

Hmong
COV NTAUB NTAWV LUS TSEEM CEEB:

Japanese
言語支援サービスについての重要なお知らせ:
お客様には、以下権利があり、必要なサービスをご利用いただける可能性があります。お客様は、通訳または翻訳のサービスを無料でご利用いただけます。言語によっては、文書化された情報を無料でご利用できる場合もあります。ご希望の言語による援助をご希望の方は、お客様の医療保険プランにご連絡ください。UnitedHealthcare of California 1-800-624-8822 / TTY: 711。この他のサポートが必要な場合には、HMO Help Line に 1-888-466-2219 にてお問い合わせください。

Korean
중요 언어 정보:
ВАЖНАЯ ЯЗЫКОВАЯ ИНФОРМАЦИЯ:
Вам могут полагаться следующие права и услуги. Вы можете получить бесплатную помощь устного переводчика или письменный перевод. Письменная информация может быть также доступна на ряде языков бесплатно. Чтобы получить помощь на вашем языке, пожалуйста, позвоните по номеру вашего плана: UnitedHealthcare of California 1-800-624-8822 / линия TTY: 711. Если вам все еще требуется помощь, позвоните в службу поддержки HMO по телефону 1-888-466-2219.

РУССКИЙ

Tagalog

MAHALAGANG IMPORMASYON SA WIKA:

Vietnamese

THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:
Nondiscrimination Notice and Access to Communication Services

UnitedHealthcare does not exclude, deny Covered Health Care Benefits to, or otherwise discriminate against any Member on the ground of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability for participation in, or receipt of the Covered Health Care Services under, any of its Health Plans, whether carried out by UnitedHealthcare directly or through a Network Medical Group or any other entity with which UnitedHealthcare arranges to carry out Covered Health Care Services under any of its Health Plans.

Free services are available to help you communicate with us such as letters in other languages, or in other formats like large print. Or, you can ask for an interpreter at no charge. To ask for help, please call the toll-free number listed on your health plan ID card.

If you think you weren’t treated fairly because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

**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.

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](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf)  
**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