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, call 1-866-314-0335 or visit welcometouhc.com. 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/glossary or call 1

Common Medical Event	Services You May Ne	What You Will Pay		Limitations, Exceptions, & Other Important Informa
		Network Provider (You will pay the least	Out-of-Network Provider (You will pay the most	

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		Network Provider (You will pay the least	Out-of-Network Provider (You will pay the most	
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice or facility benefit reduces to 50% allowed amount
If your child needs dental or eye care	& K L O G U H Q ¶ V	20% coinsurance	Not Covered	Limited to 1 exam every 2 years. No coverage out-of-network

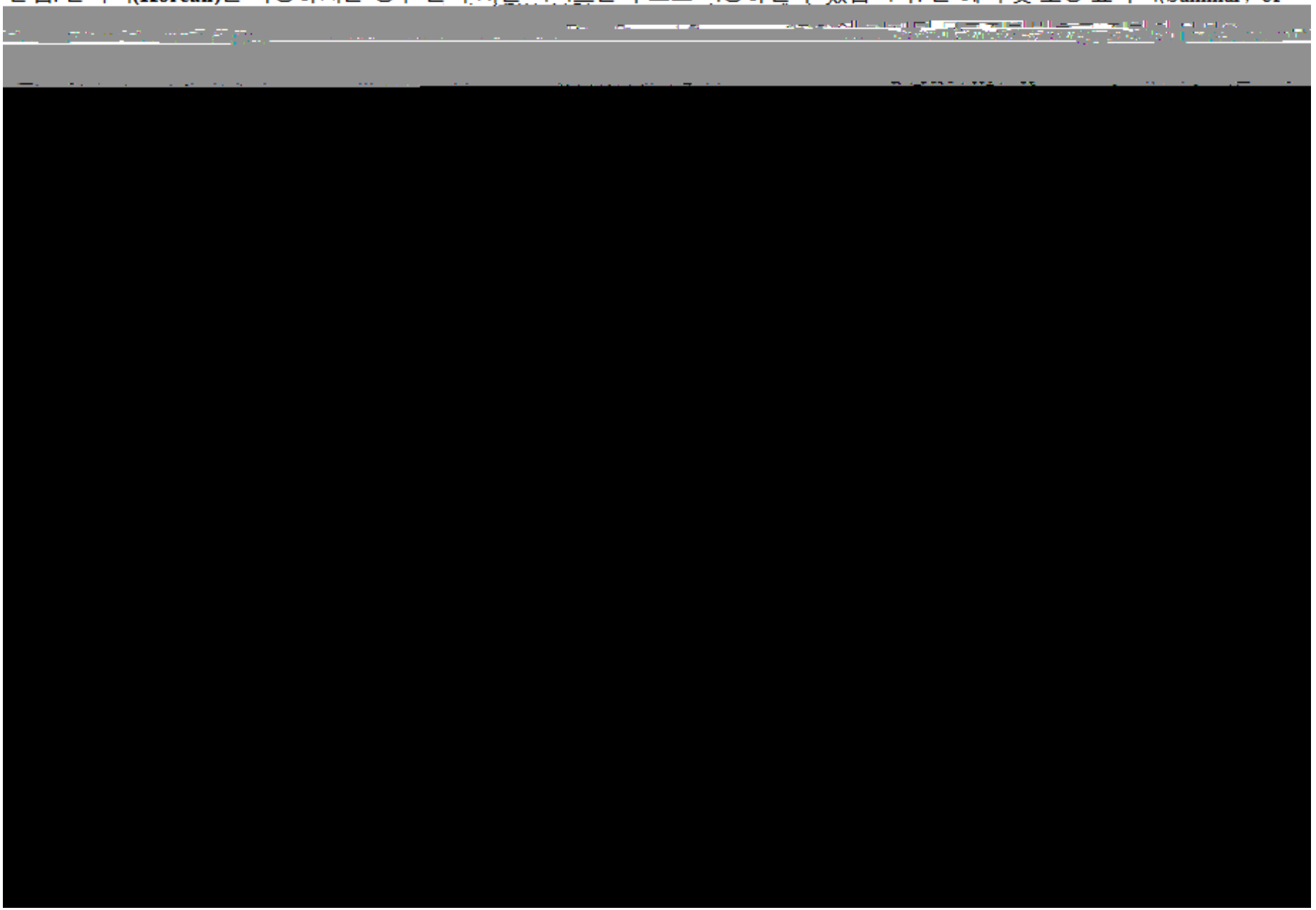
* For more information about limitations and exceptions, see the policy document at

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: _____
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.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of



ा सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायत