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. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling United Healthcare at 1-800-577-8539 or visiting www.myuhc.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 https://digital.alight.com/nokia or call 1-888-232-4111 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network -$0 Individual/$0 Family, Non-Network -$775 Individual/$2,325 Family Per Calendar Year. Does not apply to copays and services listed as "No Charge"	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. In-network services have no 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. There is a separate deductible for retail non-network prescription drug purchases.	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 - $1,600 Individual/$4,800 Family Non- Network - $4,450 Individual/$13,350 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?	Premium, deductible, balance-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-authorization and copayments.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at https://digital.alight.com/nokia or call 1-888-232-4111 to request a copy.

Will you pay less if you use a network provider?	Yes, see www.myuhc.com or call 1-800-577-8539 for a list of in-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 permission from this plan.

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* For more information about limitations and exceptions, see the plan or policy document at www.myuhc.com.

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	$35 copay/visit	25% coinsurance	Virtual visit – In-network $35 copay by a Designated Virtual Network Provider. No virtual visit coverage for out-of-network
	Specialist visit	$35 copay/visit	25% coinsurance	----------none----------
	Preventive care/screening/ immunization	$35 copay/visit	25% coinsurance	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	5% coinsurance	25% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	5% coinsurance	25% coinsurance	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Caremark.com	Generic drugs	$10 copay/retail prescription and $20 copay/mail prescription	30% coinsurance	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription). After a maintenance prescription is filled 3 times at retail, a $20 retail copay applies
	Preferred brand drugs	$30 copay/retail prescription and $60 copay (mail prescription	30% coinsurance	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription). After a maintenance prescription is filled 3 times at retail, a $60 retail copay applies
	Non-preferred brand drugs	$50 copay/retail prescription and $100 copay/mail prescription	30% coinsurance	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription). After a maintenance prescription is filled 3 times at retail, a $100 retail copay applies
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	25% coinsurance	----------none----------
	Physician/surgeon fees	5% coinsurance	25% coinsurance	----------none----------
If you need immediate medical attention	Emergency room care	$75 copay/visit	$75 copay/visit	----------none----------
	Emergency medical transportation	5% coinsurance	5% coinsurance	----------none----------

* For more information about limitations and exceptions, see the plan or policy document at www.myuhc.com.

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)	
	Urgent care	$35 copay/visit	25% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coins after $125 copay/admit	25% coins after $375 copay/admit	Prior Authorization for Non-Network
	Physician/surgeon fees	5% coinsurance	25% coinsurance	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit	25% coinsurance	----------none----------
	Inpatient services	5% coins after $125 copay/admit	25% coins after $375 copay/admit	Prior Authorization for Non-Network
If you are pregnant	Office visits	5% coins after $35 copay/first visit	25% coinsurance	Exempt from the Women's Preventive law
	Childbirth/delivery professional services	5% coinsurance	25% coinsurance	----------none----------
	Childbirth/delivery facility services	5% coins after $125 copay/admit	25% coins after $375 copay/admit	Prior Authorization for stays of 48 & 96 hours (C-section)
If you need help recovering or have other special health needs	Home health care	5% coinsurance	25% coinsurance	100 visits/calendar year for non-network. Prior Authorization required
	Rehabilitation services	$35 copay/5% coins/visit	25% coinsurance	Speech has 30 visit limit for non-network
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	5% coinsurance	25% coinsurance	60 days per calendar year for Non-Network; Prior Authorization required
	Durable medical equipment	5% coinsurance	25% coinsurance	Every 3 years repair and replace
	Hospice services	5% coinsurance	25% coinsurance	Combined 210 days lifetime. Prior Authorization for Non-Network
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	----------none----------
	Children's glasses	Not Covered	Not Covered	----------none----------
	Children's dental check-up	Not Covered	Not Covered	----------none----------

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)
- Infertility treatment
- Long-term care
- 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 (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Most coverage provided outside the United States. See www.myuhc.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-800-577-8539. 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. 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, this notice, or assistance, contact: your human resource department or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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 1-800-577-8539;
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-577-8539;
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-577-8539;
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-577-8539.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.myuhc.com.

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	$0
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	5%
Other *[cost sharing]*	5%

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	$0
Copayments	$480
Coinsurance	$620
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,160**

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	5%
Other *[cost sharing]*	5%

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	$0
Copayments	$1,593
Coinsurance	$7
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,655**

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	5%
Other *[cost sharing]*	5%

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	$0
Copayments	$330
Coinsurance	$54
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$384**

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