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| **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 1-877-769-7304.or visit [welcometouhc.com](http://www.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/sbc-glossary/](https://www.healthcare.gov/sbc-glossary/) or call 1-866-487-2365 to request a copy. |

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| **Important Questions** | | **Answers** | **Why This Matters:** |
| **What is the overall deductible?** | | Network\*: **$100** Individual / **$200** Family  Out-of-Network\*: **$100** Individual / **$200** Family  \*Deductibles cross apply.  Per calendaryear. | Generally, you must pay all of the costs from providers up to the deductibleamount 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 deductibleexpenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | | Yes. Preventive care is 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/](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there other**  **deductibles for specific services?** | | No. | You don’t have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?**  Per calendar year. | | **Medical:**  Network\*: **$500** Individual / **$1,000** Family  Out-of-Network\*: **$500** Individual / **$1,000** Family  **Prescription Drugs:**  **$4600** Individual / **$9200** 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.  \*Out-of-pocket limits cross apply. |
| **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 [myuhc.com](http://www.myuhc.com)or call **1-877-769-7304** 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. |
| **Exclamation** | All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. | | |

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| **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 | 10% coinsurance | 25% coinsurance | Virtual visits - 10% coinsurance by a Designated Virtual Network Provider. No virtual coverage out-of-network |
| Specialist visit | 10% coinsurance | 25% coinsurance | None |
| Preventive care/screening/  immunization | No Charge | 25% coinsurance | 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) | 10% coinsurance | 25% coinsurance | Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. |
| Imaging (CT/PET scans, MRIs) | 10% coinsurance | 25% coinsurance | None |
| **If you need drugs to treat your illness or condition (Deductible does not apply)** | Tier 1 – Generic | Retail or Mail Order: $5 | Retail or Mail Order: $5 | Prescription benefits are offered through CVS  Call: 855-559-1387 for more details  Retail: Maximum 30-day supply  Mail Order: Maximum 90-day supply |
| Tier 2 – Preferred Brand | Retail or Mail Order: $10 | Retail or Mail Order: $10 |
| Tier 3 – Non-Preferred Drug | Retail or Mail Order: $10 | Retail or Mail Order: $10 |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 25% coinsurance | Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. |
| Physician/surgeon fees | 10% coinsurance | 25% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 10% coinsurance | 20% coinsurance | None |
| Emergency medical transportation | 10% coinsurance | 20% coinsurance | None |
| Urgent care | 10% coinsurance | 25% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 25% coinsurance | Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| Physician/surgeon fees | 10% coinsurance | 25% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 10% coinsurance | 25% coinsurance | Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. |
| Inpatient services | 10% coinsurance | 25% coinsurance | Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| **If you are pregnant** | Office visits | No Charge | 25% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| Childbirth/delivery professional services | 10% coinsurance | 25% coinsurance |
| Childbirth/delivery facility services | 10% coinsurance | 25% coinsurance | Inpatient preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount. |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 25% coinsurance | Limited to 100 visits per calendar year.  Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| Rehabilitation services | 10% coinsurance. | 25% coinsurance | Limits per calendar year: Physical, Speech, Occupational, Cardiac, Pulmonary: Unlimited |
| Habilitative services | 10% coinsurance | 25% coinsurance | Services are provided under Rehabilitation Services above. |
| Skilled nursing care | 10% coinsurance | 20% coinsurance | Skilled Nursing is limited to 30 days per calendar year. Inpatient rehabilitation limited to 30 days.  Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| Durable medical equipment | 10% coinsurance | 25% coinsurance | Preauthorization is required out-of-network for DME over $1,000 or no coverage. |
| Hospice services | 10% coinsurance | 25% coinsurance | Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount. |
| **If your child needs dental or eye care** | Children’s eye exam | No Charge | Subject to Reasonable & Customary Charges | Limited to1 exam every year. |
| Children’s glasses | No Charge | Subject to Reasonable & Customary Charges | Limited to 1 pair every 2years. Costs may increase depending on the frames selected. |
| Children’s dental check-up | Not Covered | Not Covered | No coverage for Children’s Dental check-up. |

**Excluded Services & Other Covered Services:**

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| --- | --- | --- |
| **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 * Hearing aids | * Infertility treatment * Long-term care * Non-emergency care when travelling outside - the U.S. * Prescription drugs | * Private duty nursing * Routine foot care – Except as covered for Diabetes * Weight loss programs |

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| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)** | | |
| * Acupuncture * Bariatric surgery | * Chiropractic (Manipulative care) | * Routine eye care - 1 exam per year * Vision Materials |

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://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](http://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: the Member Service number listed on the back of your ID card or [[myuhc.com](http://www.myuhc.com)](http://www.myuhc.com/).   
  
Additionally, a consumer assistance program may help you file your appeal. Contact [dol.gov/ebsa/healthreform](https://www.dol.gov/ebsa/healthreform).

**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 1-877-769-7304.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-769-7304.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-769-7304.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-769-7304.

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

**About these Coverage Examples:**

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| **Exclamation** | **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. |

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| |  |  | | --- | --- | | **Peg is Having a Baby**  (9 months of in-network pre-natal care and a hospital delivery) | | | ◼ **The plan’s overall deductible** | **$100** | | ◼ **Specialist coinsurance** | **10%** | | ◼ **Hospital (facility) coinsurance** | **10%** | | ◼ **Other** **coinsurance** | **10%** |   **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 | $100 | | Copayments | $0 | | Coinsurance | $400 | | *What isn’t covered* | | | Limits or exclusions | $70 | | **The total Peg would pay is** | **$570** | | |  |  | | --- | --- | | **Managing Joe’s type 2 Diabetes** (a year of routine in-network care of a well-controlled condition) | | | ◼ **The plan’s overall deductible** | **$100** | | ◼ **Specialist coinsurance** | **10%** | | ◼ **Hospital (facility) coinsurance** | **10%** | | ◼ **Other** **coinsurance** | **10%** |   **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** | **$5,600** |     **In this example, Joe would pay:**   |  |  | | --- | --- | | *Cost Sharing* | | | Deductibles | $100 | | Copayments | $0 | | Coinsurance | $100 | | *What isn’t covered* | | | Limits or exclusions | $4,300 | | **The total Joe would pay is** | **$4,500** | | |  |  | | --- | --- | | **Mia’s Simple Fracture** (in-network emergency room visit and  follow up care) | | | ◼ **The plan’s overall deductible** | **$100** | | ◼ **Specialist coinsurance** | **10%** | | ◼ **Hospital (facility) coinsurance** | **10%** | | ◼ **Other** **coinsurance** | **10%** |   **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 | $100 | | Copayments | $0 | | Coinsurance | $300 | | *What isn’t covered* | | | Limits or exclusions | $10 | | **The total Mia would pay is** | **$410** | |

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](mailto: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.





