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| **The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**. The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#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 1-877-440-5983.or visit [welcometouhc.com](http://www.welcometouhc.com/). For general definitions of common terms, such as [allowed amount](https://www.healthcare.gov/sbc-glossary/#allowed-amount), [balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing), [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance), [copayment](https://www.healthcare.gov/sbc-glossary/#copayment), [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider](https://www.healthcare.gov/sbc-glossary/#provider), or other underlined terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) 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**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | Network: **$200** Individual / **$500** Family  Out-Of-Network: **$400** Individual / **$1,000** Family  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**](https://www.healthcare.gov/sbc-glossary/#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 annual 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 services at [www.healthcare.gov/coverage/preventive-care-benefits/](file://unpiox03pn/homedirs/akonesk/BPST/BPST/2016%20projects/2017%20SBC%20Template/Final%20Templates/www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | **Yes** | Skin Excisions-once per lifetime $1,000 benefit specific deductible in addition to individual deductible. |
| **What is the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | Network: **$600** Individual / **$1,500** Family  Out-Of-Network: **$1,200** Individual / **$3,000** Family  Per calendar year. | 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**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | Premiums, balance-billing charges, health care this plan doesn’t cover and penalties for failure to obtain pre-authorization 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**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Yes. See [myuhc.com](http://www.myuhc.com)or call **1-877-440-5983** for a list of network providers. | You pay the least if you use a provider in the 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**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | No. | You can see the specialist you choose without a referral. |

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| **Exclamation** | All [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#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)** | **Non-Network Provider**  **(You will pay the most)** |
| **If you visit a health care** [**provider’s**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness | $20 copay per visit, deductible does not apply. | 20% coinsurance | Virtual visits - 0% coinsurance 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](https://www.healthcare.gov/sbc-glossary/#specialist) visit | $20-40 copay per visit depending on provider’s Tier 1 status, deductible does not apply. | 20% coinsurance | If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/  immunization | No Charge | 20% 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](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | No Charge | 20% coinsurance | Pre-authorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. |
| Imaging (CT/PET scans, MRIs) | 0% coinsurance | 20% coinsurance | Pre-authorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. |
| **If you need drugs to treat your illness or condition**  More information about [prescription drug coverage](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at [www.optumrx.com](http://www.optumrx.com) | Tier 1 – Your Lowest Cost Option | Retail: $5 (up to 31 days)  $15 (up to 90 days)  Mail-Order: $12.50 | Not Covered | Provider means pharmacy for purposes of this section.  Retail: Up to a 31 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. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.  Certain drugs may have a pre-authorization requirement or may result in a higher cost. Certain preventive medications (including certain contraceptives) are covered at No Charge.  See the website listed for information on drugs covered by your plan. Not all drugs are covered. No coverage for prescription drugs with UnitedHealthcare.  You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a Non-Preferred brand drug is available as a Generic drug, and the Non-preferred brand is chosen over its Generic, an additional ancillary fee is charged.  Out of Pocket limit:$4,000 Individual/$10,00 Family. |
| Tier 2 – Your Mid-Range Cost Option | Retail: $25 (up to 31 days)  $75 (up to 90 days)  Mail-Order: $125 | Not Covered |
| Tier 3 – Your Mid-Range Cost Option | Retail: $50 (up to 31 days)  $150 (up to 90 days)  Mail-Order: $125 | Not Covered |
| Tier 4 – Specialty Drugs | (up to 31 days)  Tier 1: $5 copay  Tier 2: $25 copay  Tier 3: 10% up to $150  (32-90 days)  Tier 1: $12.50  Tier 2: $62.50  Tier 3: 10% up to $300 copay | Not Covered |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | 20% coinsurance | Pre-authorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. |
| Physician/surgeon fees | 0% coinsurance | 20% coinsurance | None |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | $150 copay per visit deductible does not apply. | $150 copay per visit, , deductible does not apply. | None. Copay waived if admitted directly to hospital or skilled nursing facility directly from Emergency Room. |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | 0% coinsurance, deductible does not apply. | 0% coinsurance, deductible does not apply. |  |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | $25 copay per visit, deductible does not apply. | 20% 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 | 20% coinsurance | Pre-authorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| Physician/surgeon fees | 0% coinsurance | 20% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 copay per visit after first 30 visits at no copay, deductible does not apply. | 20% coinsurance | EAP/Behavioral Health Virtual Visit on liveandworkwell.com-0% coinsurance, deductible does not apply. Pre-authorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.  See your policy or plan document for additional information about EAP benefits. |
| Inpatient services | 0% coinsurance | 20% coinsurance | Pre-authorization is required out-of-network or benefit reduces to 50% of allowed amount.  See your policy or plan document for additional information about EAP benefits. |
| **If you are pregnant** | Office visits | No Charge after 1st initial visit which $20 copay applies | 20% 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 | 0% coinsurance | 20% coinsurance |
| Childbirth/delivery facility services | 0% coinsurance | 20% coinsurance | Inpatient pre-authorization 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](https://www.healthcare.gov/sbc-glossary/#home-health-care) | 0% coinsurance | 20% coinsurance | Limited to 120 visits per calendar year.  Pre-authorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | $20 copay per visit, deductible does not apply. | 20% coinsurance | Limits per calendar year: Physical, Speech, Occupational, Cardiac, Pulmonary: 25 visits each |
| [Habilitative services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | $20 copay per visit, deductible does not apply. | 20% coinsurance | Services are provided under and limits are combined with Rehabilitation Services above. |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | 0% coinsurance | 20% coinsurance | Limited to 100 days per calendar year. Inpatient rehabilitationlimited to 45 days per calendar year.  Pre-authorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | 0% coinsurance | 20% coinsurance | Covers 1 per type of DME (including repair/replacement) every 3 years. Pre-authorization is required out-of-network for DME over $1,000 |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | No Charge | 20% coinsurance | Pre-authorization 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 | $20 copay per outpatient visit | 20% coinsurance | None |
| Children’s glasses | Not Covered | Not Covered | No coverage for Children’s glasses. Full vision benefits available under Vision Plan. |
| Children’s dental check-up | Not Covered | Not Covered | No coverage for Children’s Dental check-up. Full dental coverage available under Dental Plan. |

**Excluded Services & Other Covered Services:**

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| **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** | | |
| * Acupuncture * Adult/Children’s glasses * Cosmetic surgery | * Infertility treatment * Long-term care * Non-emergency care when travelling outside - the U.S. | * 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**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** | | |
| * Bariatric surgery * Chiropractic (Manipulative care)– 25 visits per calendar year | * Dental care * Gender Identity Disorder * Hearing aids | * Nutritional counseling * Routine eye care – Adult/Children |

**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](https://www.healthcare.gov/sbc-glossary/#marketplace). For more information about the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim](https://www.healthcare.gov/sbc-glossary/#claim). This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal](https://www.healthcare.gov/sbc-glossary/#appeal). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](https://www.healthcare.gov/sbc-glossary/#claim). Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information to submit a [claim](https://www.healthcare.gov/sbc-glossary/#claim), [appeal](https://www.healthcare.gov/sbc-glossary/#appeal), or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan](https://www.healthcare.gov/sbc-glossary/#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**

If you don’t have [Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t meet the [Minimum Value Standards](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard), you may be eligible for a [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-440-5983.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-440-5983.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-440-5983.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-440-5983.

––––––––––––––––––––––*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](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles](https://www.healthcare.gov/sbc-glossary/#deductible), [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan](https://www.healthcare.gov/sbc-glossary/#plan). Use this information to compare the portion of costs you might pay under different health [plans](https://www.healthcare.gov/sbc-glossary/#plan). 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**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | **$200** | | ◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) **copay** | **$20** | | ◼ **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 | $200 | | Copayments | $20 | | Coinsurance | $0 | | *What isn’t covered* | | | Limits or exclusions | $60 | | **The total Peg would pay is** | **$280** | | |  |  | | --- | --- | | **Managing Joe’s type 2 Diabetes** (a year of routine in-network care of a well-controlled condition) | | | ◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | **$200** | | ◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) **copay** | **$20** | | ◼ **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 | $200 | | Copayments | $800 | | Coinsurance | $0 | | *What isn’t covered* | | | Limits or exclusions | $30 | | **The total Joe would pay is** | **$1,030** | | |  |  | | --- | --- | | **Mia’s Simple Fracture** (in-network emergency room visit and  follow up care) | | | ◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | **$200** | | ◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) **copay** | **$20** | | ◼ **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 | $200 | | Copayments | $300 | | Coinsurance | $0 | | *What isn’t covered* | | | Limits or exclusions | $0 | | **The total Mia would pay is** | **$500** | |

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.





