



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 (866) 351-6831 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/sbc-glossary/ or call (866) 487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network: \$0 Individual / \$0 Family Non-Network: \$200 Individual / \$600 Family Per calendar year.	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 ?	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.
Are there other deductibles for specific services?	Yes. There is a \$50 annual deductible under the Home Health Care benefits.	In most cases you don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan ?	Network: \$0 Individual / \$0 Family Non-Network: \$650 Individual Per calendar year.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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 Prenotification for services, prescription drugs and copays.	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. This plan uses network providers . If you use a non-network provider your cost may be more. For a list of providers , see myuhc.com for UHC Options PPO network, www.empireplanproviders.com/provider.htm for Empire Plan Network, or call (866) 351-6831, or United Behavioral Health (UBH) at myuhc.com or (866) 374-6060.	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 .



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)	Non-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	\$25 copay per visit	20% coinsurance	Virtual visits - \$15 copay per visit by a Designated Virtual Network Provider, deductible does not apply. No virtual coverage out-of-network If you receive services in addition to office visit, additional copays , deductibles or coinsurance may apply.
	Specialist visit	\$25 copay per visit	20% coinsurance	If you receive services in addition to office visit, additional copays , deductibles or coinsurance may apply.
	Preventive care/screening/immunization	\$25 copay per visit	20% coinsurance	Coverage limited for mammograms and pap smears. Routine physicals, well-child care visits and immunizations are not covered.
If you have a test	Diagnostic test (x-ray, blood work)	No charge up to \$1,500 outpatient benefit maximum, then \$25 copay	No charge up to \$1,500 outpatient benefit maximum, then 20% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	No charge up to \$1,500 outpatient benefit maximum, then \$25 copay	No charge up to \$1,500 outpatient benefit maximum, then 20% coinsurance after deductible	None

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 need drugs to treat your illness or condition	Tier 1 – Your Lowest Cost Option	Retail: \$5 <u>copay</u> Mail-Order: \$12.50 <u>copay</u>	Retail: \$5 <u>copay</u> Mail Order: 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. Covered by CVS Caremark. See www.Caremark.com for information and drugs covered by your plan. CVS Caremark Customer Service: (844) 449-0372 / CVS Caremark Specialty Pharmacy: (800) 237-2767. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-notification requirement or may result in a higher cost. Tier 1 contraceptives covered at No Charge. If you use a non-network Pharmacy, you are responsible for any amount over the allowed amount. Not all drugs are covered.
	Tier 2 – Your Mid-Range Cost Option	Retail: \$20 <u>copay</u> Mail-Order: \$50 <u>copay</u>	Retail: \$20 <u>copay</u> Mail Order: Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$35 <u>copay</u> Mail-Order: \$87.50 <u>copay</u>	Retail: \$35 <u>copay</u> Mail Order: Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	None
	Physician/surgeon fees	No Charge	No Charge	Subject to second surgical opinion and ambulatory care guidelines.
If you need immediate medical attention	Emergency room care	No charge up to \$1,500 outpatient benefit maximum, then \$25 <u>copay</u>	No charge up to \$1,800 outpatient benefit maximum, then \$25 <u>copay</u>	None
	Emergency medical transportation	No charge up to \$75, then \$25 <u>copay</u>	No charge up to \$150, then \$25 <u>copay</u>	None
	Urgent care	\$25 <u>copay</u> per visit	20% <u>coinsurance</u>	If you receive services in addition to <u>Urgent care</u> visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	<u>Prenotification</u> is required or a \$250 penalty applies.
	Physician/surgeon fees	No charge up to \$1,800 benefit maximum, then \$25 <u>copay</u>	No Charge, up to benefit maximum of \$1,800, then 20% <u>coinsurance</u>	None

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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> per visit	20% <u>coinsurance</u>	Network Partial hospitalization/intensive outpatient treatment: No Charge
	Inpatient services	No Charge	No Charge	<u>Prenotification</u> is required or a \$250 penalty applies.
If you are pregnant	Office visits	\$25 <u>copay</u> for first visit	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No Charge	No Charge	
	Childbirth/delivery facility services	No Charge	No Charge	Prenotification applies if stay exceeds 48 hours (C-Section: 96 hours).
If you need help recovering or have other special health needs	Home health care	*25% <u>coinsurance</u>	*25% <u>coinsurance</u> after deductible	Limited to 40 visits per calendar year. Prenotification is required or a \$250 penalty applies. A separate \$50 annual <u>deductible</u> applies.
	Rehabilitation services	\$25 <u>copay</u> per visit	20% <u>coinsurance</u>	Depending on the type of therapy, there may be limited visits per calendar year.
	Habilitative services	Not Covered	Not Covered	No coverage for habilitation services.
	Skilled nursing care	No Charge	No Charge	Prenotification is required or a \$250 penalty applies.
	Durable medical equipment	\$25 <u>copay</u> per device	20% <u>coinsurance</u>	Limitations may apply.
	Hospice services	No Charge	0% coinsurance	<u>Prenotification</u> is required before admission for an Inpatient Stay in a hospice facility or a \$250 penalty applies.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.

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)	
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

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 .)		
<ul style="list-style-type: none"> Children's glasses Cosmetic surgery Hearing aids 	<ul style="list-style-type: none"> Infertility treatment Long-term care Non-emergency care when travelling outside - the U.S. 	<ul style="list-style-type: none"> Private duty nursing Routine foot care – Except as covered for Diabetes Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Acupuncture Bariatric Surgery Chiropractic (Manipulative care) – limitations apply 	<ul style="list-style-type: none"> Dental Care – limitations may apply 	<ul style="list-style-type: none"> Routine eye care – limitations may apply

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 (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (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 (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: the Member Service number listed on the back of your ID card or myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? This plan or policy **does not provide** minimum essential coverage. This plan has maintained “Grandfathered” status. Therefore, the minimum essential benefit provisions do not apply.

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? This health coverage **does meet** the minimum value standard for the benefits it provides.

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 (866) 351-6831.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (866) 351-6831.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (866) 351-6831.

Navajo (Dine): Dinekehgo shika at’ohwol ninisingo, kwijigo holne’ (866) 351-6831.

————— *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.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist copay	\$25
■ Hospital (facility) copay	\$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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$100
The total Peg would pay is	\$300

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 copay	\$25
■ Hospital (facility) copay	\$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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,060

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copay	\$25
■ Hospital (facility) copay	\$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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$300

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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

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 (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.
