UnitedHealthcare

# Standard Plan

**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, visit www.myuhc.com or call 1-800-577-8359. 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://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-800-577-8359 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: $1,000 Individual / $3,000 Family Non-Network: $2,000 Individual / $6,000 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?** | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| **Are there other deductibles for specific services?** | No, there are no other deductibles. | 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?** | Medical- For network provider: $6,000 Individual / $12,000 Family For out-of-network providers: $12,000 Individual / $36,000 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?** | Premiums, balance-billing charges, deductibles, health care this plan doesn't cover, penalties for failure to obtain prior authorization for services. | Even though you pay these expenses, they don't count toward the out-of-pocket. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See www.myuhc.com or call 1-800-577-8359 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. |

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 | 50% coinsurance | If you receive services in addition to office visit, additional copays, deductibles, or coins may apply. Virtual visit – in-network $20 copay per visit by a Designated Virtual Network Provider. No virtual visit coverage for out of network. |
| | Specialist visit | $60 copay/visit | 50% coinsurance | If you receive services in addition to office visit, additional copays, deductibles, or coins may apply. |
| | Preventive care/screening/ immunization | No charge | 50% 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) | No charge | 50% coinsurance | Prior Authorization required out-of-network for Sleep Studies or $400 penalty 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) | |
| | Imaging (CT/PET scans, MRIs) | 25% coinsurance | 50% coinsurance | None |
| **If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Caremark.com** | Generic Drugs (Tier 1) | Retail: $20 copay Mail Order: $50 copay | Retail: 50% coinsurance after deductible of $225 Individual/$450 Two-person/$675 Family | Prescription drug copays will double after the third time you receive a 30-day supply of a maintenance medication at a retail pharmacy. |
| | Preferred brand drugs (Tier 2) | Retail: 50% coinsurance with an out-of-pocket minimum of $30 and maximum of $150/prescription Mail Order: 50% coinsurance with an out-of-pocket minimum of $75 and maximum of $375/prescription | Retail: 50% coinsurance after deductible of $225 Individual/$450 Two-person/$675 Family | Prescription drug copays will double after the third time you receive a 30-day supply of a maintenance medication at a retail pharmacy. You will pay the generic copay, plus the difference in cost between the brand-name and generic drug, if you purchase a brand-name drug when a generic equivalent is available. |
| | Non-preferred brand drugs (Tier 3) | Retail: 50% coinsurance with an out-of-pocket minimum of $30 and maximum of $150/prescription Mail Order: 50% coinsurance with an out-of-pocket minimum of $75 and maximum of $375/prescription | Retail: 50% coinsurance after deductible of $225 Individual/$450 Two-person/$675 Family | Prescription drug copays will double after the third time you receive a 30-day supply of a maintenance medication at a retail pharmacy. You will pay the generic copay, plus the difference in cost between the brand-name and generic drug, if you purchase a brand-name drug when a generic equivalent is available. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $300 copay/visit 25% coinsurance | 50% coinsurance | Prior Authorization required out-of-network or $400 penalty applies. |
| | Physician/surgeon fees | 25% coinsurance | 50% coinsurance | None |

| 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 need immediate medical attention** | Emergency room care | $300 copay/visit | $300 copay/visit | None |
| | Emergency medical transportation | 25% coinsurance | 25% coinsurance | None |
| | Urgent care | $100 copay/visit | 50% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $500 copay/visit, 25% coinsurance | $700 copay/visit, 50% coinsurance | A $500 in-network per confinement copay and a $700 out-of-network per confinement copay applies in addition to plan deductible. Prior Authorization required out-of-network or $400 penalty applies. |
| | Physician/surgeon fees | 25% coinsurance | 50% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $35 copay/visit | 50% coinsurance | Prior Authorization required for certain services out-of-network or $400 penalty applies. Partial Hospitalization/Intensive Outpatient Treatment: in-network 25%, no deductible; out-of-network 50% after plan deductible. |
| | Inpatient services | $500 copay/visit, 25% coinsurance | $700 copay/visit, 50% coinsurance | A $500 in-network per confinement copay and a $700 out-of-network per confinement copay applies in addition to plan deductible. Prior Authorization required out-of-network for inpatient facility or $400 penalty applies. |
| **If you are pregnant** | Office visits | $35 copay/initial visit only | 50% coinsurance | |
| | Childbirth/delivery professional services | 25% coinsurance | 50% coinsurance | |

| 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) | |
| | Childbirth/delivery facility services | $500 copay/visit, 25% coinsurance | $700 copay/visit, 50% coinsurance | A $500 in-network per confinement copay and a $700 out-of-network per confinement copay applies in addition to plan deductible. Prior Authorization required out-of-network for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or $400 penalty applies. 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). |
| **If you need help recovering or have other special health needs** | Home health care | 25% coinsurance | 50% coinsurance | Limited to 100 visits per calendar year for Home Health Care out-of-network only. Limited to 100 visits per calendar year for Outpatient Private Duty Nursing out-of-network only. Prior Authorization required out-of-network for Home Health Care for certain services (skilled nursing by RN or LPN) or $400 penalty applies. |
| | Rehabilitation services | $60 copay/visit | 50% coinsurance | Speech Therapy limited to 30 visits per calendar year out-of-network only; 100 visits per calendar year for developmental delays out-of-network only. |
| | Habilitation services | Not covered | Not covered | Habilitation Services are not covered. |

| 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) | |
| | Skilled nursing care | 25% coinsurance | 50% coinsurance | Limited to 60 days per calendar year out-of-network only. Prior Authorization required out-of-network or $400 penalty applies. |
| | Durable medical equipment | 25% coinsurance | 50% coinsurance | Prior Authorization required out-of-network for DME over $1,000 or will not be covered. |
| | Hospice services | 25% coinsurance | 50% coinsurance | Prior Authorization required out-of-network before admission for an inpatient stay in a hospice facility or $400 penalty applies. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Child routine vision exam is not covered. |
| | Children's glasses | Not covered | Not covered | Child glasses are not covered. |
| | Children's dental check-up | Not covered | Not covered | Child dental check-up is not covered. |

## 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.)**

- Adult routine vision exam (i.e. refraction)
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation Services
- Infertility treatment
- Long-term care
- Routine foot care

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture - 30 visits per calendar year (out-of-network only)
- Bariatric Surgery
- Chiropractic care - 30 visits per calendar year
- Hearing aids - $2,500 every 36 months
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - 100 visits per calendar year (out-of-network only)
- Weight loss programs

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. 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, 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: 1-800-577-8359 or visit 1-800-577-8359 or the Employee Benefits Security Administration at 1-866-444-3272 or 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 1-800-577-8359.

Traditional Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-577-8359.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-577-8359.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-577-8359 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-577-8359.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-577-8359.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-577-8359.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-577-8359.

*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** | **$1,000** |
| ■ **Specialist copayment** | **$60** |
| ■ **Hospital (facility) copayment** | **$500** |
| ■ **Other coinsurance** | **25%** |

**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 | $1,000 |
| Copayments | $500 |
| Coinsurance | $800 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Peg would pay is** | **$2,370** |

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

| | |
|---|---|
| ■ **The plan's overall deductible** | **$1,000** |
| ■ **Specialist copayment** | **$60** |
| ■ **Hospital (facility) copayment** | **$500** |
| ■ **Other coinsurance** | **25%** |

**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 | $1,000 |
| Copayments | $50 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $4,300 |
| **The total Joe would pay is** | **$5,350** |

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

| | |
|---|---|
| ■ **The plan's overall deductible** | **$1,000** |
| ■ **Specialist copayment** | **$60** |
| ■ **Hospital (facility) copayment** | **$500** |
| ■ **Other coinsurance** | **25%** |

**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 | $1,000 |
| Copayments | $800 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Mia would pay is** | **$1,870** |