UnitedHealthcare

Choice + Traditional

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 http://welcometouhc.com or call 855-248-0896. 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 855-248-0896 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $1,000 Individual / $2,000 Family Non-Network: $2,000 Individual / $4,000 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 and primary care services with copay are 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?	For network provider: $5,000 Individual / $10,000 Family For out-of-network providers: $10,000 Individual / $20,000 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, 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 855-248-0896 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	$30 copay/visit	45% coinsurance	Virtual Visit - In-network: $30 copay per visit by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or coins may apply.
	Specialist visit	$50 copay/visit	45% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or co-insurance may apply.
	Preventive care/screening/ immunization	No charge	45% 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)	25% coinsurance	45% coinsurance	Prior Authorization required out-of-network for Sleep Studies or benefit will not be covered.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	45% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay: <u>Network Provider</u> (You will pay the least)	What You Will Pay: <u>Out-of-Network Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <u>www.welcometouhc.com</u>	Generic Drugs (Tier 1)	Retail: $12 <u>copay</u> Mail Order: $30 <u>copay</u>	Retail: 45% <u>coinsurance</u> <u>deductible</u> does not apply Mail Order: 45% <u>coinsurance</u> <u>deductible</u> does not apply	Retail: $12.00 copay. Mail Order: $30.00 copay Retail up to 31-day supply. Mail up to 90 days supply.
	Preferred brand drugs (Tier 2)	Retail: 25% <u>coinsurance</u> <u>deductible</u> does not apply Mail Order: 25% <u>coinsurance</u> <u>deductible</u> does not apply	Retail: 45% <u>coinsurance</u> <u>deductible</u> does not apply Mail Order: 45% <u>coinsurance</u> <u>deductible</u> does not apply	Retail: 25% with a max copay of $80.00 Mail Order: 25% with a max copay of $200.00 Certain preventive medications (including certain contraceptives) are covered at No Charge.
	Non-preferred brand drugs (Tier 3)	Retail: 25% <u>coinsurance</u> <u>deductible</u> does not apply Mail Order: 25% <u>coinsurance</u> <u>deductible</u> does not apply	Retail: 45% <u>coinsurance</u> <u>deductible</u> does not apply Mail Order: 45% <u>coinsurance</u> <u>deductible</u> does not apply	Retail: 25% with a max copay of $150.00 Mail Order: 25% with a max copay of $375.00 Prior authorization is required for certain drugs or there may be no coverage.
	<u>Specialty drugs</u> (Tier 4)	Retail: 25% <u>coinsurance</u> <u>deductible</u> does not apply Mail Order: 25% <u>coinsurance</u> <u>deductible</u> does not apply	Not Covered	Retail: 25% with a max copay of $200.00 Mail Order: 25% with a max copay of $500.00. Specialty drugs must be filled through mail order by a designated OptumRx Specialty Pharmacy, Optum Specialty Pharmacy or another designated Specialty Pharmacy in the OptumRx Specialty Network, and can only be filled in 31-day supplies
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	45% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-<u>network</u> or benefit will not be 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)	
	Physician/surgeon fees	25% coinsurance	45% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay/visit, 25% coinsurance	$150 copay/visit 25% coinsurance	None
	Emergency medical transportation	25% coinsurance	25% coinsurance	None
	Urgent care	$50 copay/visit	45% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	45% coinsurance	Prior Authorization required out-of-network or benefit will not be covered.
	Physician/surgeon fees	25% coinsurance	45% coinsurance	None

<table>
<tr><th rowspan="2">Common Medical Event</th><th rowspan="2">Services You May Need</th><th colspan="2">What You Will Pay</th><th rowspan="2">Limitations, Exceptions, & Other Important Information</th></tr>
<tr><th><u>Network Provider</u>
(You will pay the least)</th><th><u>Out-of-Network Provider</u>
(You will pay the most)</th></tr>
<tr><td rowspan="2">If you need mental health, behavioral health, or substance abuse services</td><td>Outpatient services</td><td>$30 <u>copay</u>/visit</td><td>45% <u>coinsurance</u></td><td>Partial <u>Hospitalization</u>/Intensive Outpatient Treatment in-<u>network</u> 25% after <u>plan</u> <u>deductible</u> and out-of-<u>network</u> 45% after <u>plan</u> <u>deductible</u>.

Intensive Behavioral Therapy (ABA) 25% no <u>deductible</u> and out-of-<u>network</u> 45% after <u>plan</u> <u>deductible</u>.

<u>Prior Authorization</u> required for certain treatments out-of-<u>network</u> or will not be covered.

5 free counseling sessions (per family member per issue per year)

EAP through Compsych.</td></tr>
<tr><td>Inpatient services</td><td>25% <u>coinsurance</u></td><td>45% <u>coinsurance</u></td><td><u>Prior Authorization</u> required out-of-<u>network</u> for inpatient facility or benefit will not be covered.</td></tr>
<tr><td rowspan="2">If you are pregnant</td><td>Office visits</td><td>$30 <u>copay</u>/initial visit only</td><td>45% <u>coinsurance</u></td><td rowspan="2"></td></tr>
<tr><td>Childbirth/delivery professional services</td><td>25% <u>coinsurance</u></td><td>45% <u>coinsurance</u></td></tr>
</table>

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	25% coinsurance	45% coinsurance	Prior Authorization required for out-of-network for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or benefit will not be covered. 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	45% coinsurance	Limited to 120 visits per calendar year for Home Health Care. Prior Authorization required out-of-network for Home Health Care for certain services (skilled nursing by RN or LPN) or benefit will not be 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)	
	Rehabilitation services	$50 copay/visit	45% coinsurance	Pulmonary and Cardiac Rehabilitation therapy is unlimited. Occupational, Physical and Speech Therapy is limited to 60 combined visits per calendar year. Limited to 20 visits per calendar year for Cognitive Rehabilitation Therapy. Visit Limit does not apply to members with a behavioral diagnosis.
	Habilitation services	$50 copay/visit	45% coinsurance	Habilitation Services are provided, and limits are combined with Rehabilitation Services above
	Skilled nursing care	25% coinsurance	45% coinsurance	Limited to 120 days per calendar year. Prior Authorization required out-of-network or benefit will not be covered.
	Durable medical equipment	25% coinsurance	45% coinsurance	Prior Authorization required out-of-network for DME over $1,000 or benefit will not be covered.
	Hospice services	25% coinsurance	45% coinsurance	Prior Authorization required out-of-network before admission for an inpatient stay in a hospice facility or benefit will not be covered.
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.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	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)	• Long-term care • Non-emergency care when traveling outside the U.S.	• 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 • Bariatric Surgery	• Chiropractic care – Limited to 20 visits per calendar year. • Hearing aids – Limited to 1 per ear every 24 months.	• Infertility treatment – Limited to $25,000 lifetime. • Private-duty nursing – Limited to 120 visits per calendar year.

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: 855-248-0896 or visit www.welcometouhc.com 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 855-248-0896.

Traditional Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 855-248-0896.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-248-0896.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 855-248-0896 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-248-0896.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 855-248-0896.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 855-248-0896.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 855-248-0896.

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**	**$50**
■ **Hospital (facility) coinsurance**	**25%**
■ **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	$10
Coinsurance	$2,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,970**

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**	**$50**
■ **Hospital (facility) coinsurance**	**25%**
■ **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	$100
Copayments	$800
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,220**

Mia's Simple Fracture

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

■ **The plan's overall deductible**	**$1,000**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) coinsurance**	**25%**
■ **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	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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