UnitedHealthcare

**Doctors Plan EDH7 Mod / H20Y -Mod**

**Coverage For: Family | Plan Type: EPO**

**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 1-844-376-0313 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 1-866-487-2365 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: **$3,000** Individual / **$6,000** Family<br>Per policy 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 Services 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.<br>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/. |
| **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?** | Network: **$4,000** Individual / **$8,000** Family<br>Per policy 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. | 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 www.myuhc.com or call 1-844-376-0313 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 | No Charge | Not Covered | Virtual Visits - No Charge by a Designated Virtual Network Provider. Office Visit cost share applies to any other Telehealth service based on provider type. |
| | Specialist visit | $80 copay per visit, deductible does not apply | Not Covered | If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. |
| | Preventive care/ screening/ immunization | No Charge | Not Covered | 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) | Lab Testing: No Charge X-Ray/Diagnostics: 20% coinsurance, deductible does not apply | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not Covered | 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 drugs to treat your illness or condition** More information about prescription drug coverage is available at welcometouhc.com | Tier 1 - Your Lowest Cost Option | Retail: $10 copay, deductible does not apply. Mail-Order: $25 copay, deductible does not apply. Specialty Retail: 20% coinsurance, deductible does not apply. | 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 or Preferred 90 Day Retail Network Pharmacy. Specialty drugs are not covered through mail order. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. 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 preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. |
| | Tier 2 - Your Mid-Range Cost Option | Retail: $50 copay, deductible does not apply. Mail-Order: $125 copay, deductible does not apply. Specialty Retail: 20% coinsurance, deductible does not apply. | Not Covered | |
| | Tier 3 - Your Mid-Range Cost Option | Retail: $120 copay, deductible does not apply. Mail-Order: $300 copay, deductible does not apply. Specialty Retail: 20% coinsurance, deductible does not apply. | Not Covered | |
| | Tier 4 - Your Highest Cost Option | Retail: $250 copay, deductible does not apply. Mail-Order: $625 copay, deductible does not apply. Specialty Retail: 20% coinsurance, deductible does not apply. | Not Applicable | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not Covered | 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) | |
| | Physician/ surgeon fees | 20% coinsurance | Not Covered | None |
| **If you need immediate medical attention** | Emergency room care | $500 copay per visit, deductible does not apply | $500 copay per visit, deductible does not apply | None |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent Care | No Charge | Not Covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not Covered | None |
| | Physician/ surgeon fees | 20% coinsurance | Not Covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No Charge | Not Covered | Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance.<br>Intensive Behavior Therapy (ABA), TMS, ECT, MAT and Psych Testing: No Charge.<br>See your policy or plan document for additional information about EAP benefits. |
| | Inpatient services | 20% coinsurance | Not Covered | See your policy or plan document for additional information about EAP benefits. |
| **If you are pregnant** | Office Visits | No Charge | Not Covered | Cost sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | 20% coinsurance | Not Covered | 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 facility services | 20% coinsurance | Not Covered | 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 help recovering or have other special health needs** | Home health care | 20% coinsurance | Not Covered | Limited to 60 visits per policy year. |
| | Rehabilitation services | 20% coinsurance | Not Covered | Limits per policy year: Physical, Occupational, Speech, Pulmonary: 20 visits each; Cardiac: 36 visits. |
| | Habilitative services | 20% coinsurance | Not Covered | Services are provided under and limits are combined with Rehabilitation Services above.<br>No limits apply for treatment of Autism Spectrum Disorder Services. |
| | Skilled nursing care | 20% coinsurance | Not Covered | Limited to 60 days per policy year (combined with inpatient rehabilitation). |
| | Durable medical equipment | 20% coinsurance | Not Covered | Covers 1 per type of DME (including repair/replacement) every 3 years. |
| | Hospice services | 20% coinsurance | Not Covered | None |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | Not Covered | Limited to 1 exam every 24 months. |
| | 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.)**

- Bariatric surgery
- Cosmetic Surgery
- Dental Care
- Glasses
- Long Term Care
- Non-emergency care when traveling outside - the US
- 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.)**

- Acupuncture - 10 visits per policy year
- Chiropractic (manipulative) care - 20 visits per policy year
- Hearing aids
- Infertility Treatment
- Routine eye care (Adult) - 1 exam per 24 months

**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, or the U.S. Department of Health and Human Services at 1-877-267-2323 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 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 or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or Colorado Division of Insurance at 1-303-894-7490 or doi.colorado.gov/health-insurance.

**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 1-844-376-0313.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-376-0313.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-844-376-0313.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-376-0313.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-844-376-0313 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-844-376-0313.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-844-376-0313.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-844-376-0313.

***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** **$3,000**
- **Specialist copay** **$80**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

**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 | **$3,000** |
| Copayments | **$0** |
| Coinsurance | **$1,000** |
| *What isn't covered* | |
| Limits or exclusions | **$60** |
| **The total Peg would pay is** | **$4,060** |

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

- **The plan's overall deductible** **$3,000**
- **Specialist copay** **$80**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

**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 | **$200** |
| Copayments | **$400** |
| Coinsurance | **$0** |
| *What isn't covered* | |
| Limits or exclusions | **$0** |
| **The total Joe would pay is** | **$600** |

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

- **The plan's overall deductible** **$3,000**
- **Specialist copay** **$80**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

**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 | **$1,500** |
| Copayments | **$600** |
| Coinsurance | **$0** |
| *What isn't covered* | |
| Limits or exclusions | **$0** |
| **The total Mia would pay is** | **$2,100** |

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

**Appendix A**

## Colorado Supplement to the Summary of Benefit and Coverage Form

**UnitedHealthcare Insurance Company**
**Name of Carrier**

**INS Doctors Plan Plan EDH7**
**Name of Plan**

**Large Employer Group Policy**
**Policy Type**

### TYPE OF COVERAGE

| | |
|---|---|
| **1. Type of Plan** | Preferred provider organization (PPO) |
| **2. Out-of-network care covered? [1]** | Only for emergency care. |
| **3. Areas of Colorado where plan is available.** | Plan is available only in the following areas: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Denver, Douglas, El Paso, Jefferson, Larimer, Lincoln, Otero, Park, Pueblo, Teller, and Weld. |

## SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

| | Description | What this means. |
|---|---|---|
| **4. Deductible Period** | Policy Year | Benefit year deductibles restart on a date other than January 1. Please see your policy or plan document to see the date the deductible starts over. |
| **5. Annual Deductible Type** | Individual/Family | "Individual" means the deductible amount you and each individual covered by the plan will have to pay for allowable covered expenses before the carrier will cover those expenses. "Family" is the maximum deductible amount that is required to be met for all family members covered by the plan. It may be an aggregated amount(e. g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). |
| **6. What cancer screenings are covered?** | Breast Cancer Screening – Cervical Cancer Screening – Colorectal Cancer Screening – Prostate Cancer Screening | |

## LIMITATIONS AND EXCLUSIONS

| | |
|---|---|
| **7. Period during which pre-existing conditions are not covered for covered persons age 19 and older. [2]** | Not applicable; plan does not exclude coverage for pre-existing conditions. |
| **8. How does the policy define a "pre-existing condition"?** | Not applicable; plan does not exclude coverage for pre-existing conditions. |
| **9. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?** | No. |

## USING THE PLAN

| | **Using the Plan** |
|---|---|
| **10. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?** | No. |
| **11. Does the plan have a binding arbitration clause?** | No. |

**Questions:** Call 1-800-516-3344 or visit us at www.UnitedHealthcare.com
If you are not satisfied with the resolution of your complaint or grievance, contact:
Colorado Division of Insurance
Consumer Affairs Section
1560 Broadway, Suite 850, Denver CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745
Email: insurance@dora.state.co.us

## Language Access Services:

Para obtener asistencia en Español, llame al 1-844-376-0313.
如果需要中文的帮助，请拨打这个号码 1-844-376-0313.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-376-0313.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-376-0313.

## Endnotes

1 "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that this plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2 Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

UNITEDHEALTHCARE HAS PREPARED AND MAINTAINS A NETWORK ACCESS PLAN THAT DESCRIBES HOW THE PLAN MONITORS THE NETWORK OF PROVIDERS TO ENSURE THAT YOU HAVE ACCESS TO NETWORK PROVIDERS. THE ACCESS PLAN ALSO HAS INFORMATION ON THE REFERRAL PROCESSES, COMPLAINT PROCEDURES, QUALITY PROGRAMS AND EMERGENCY SERVICES COVERAGE PROVISIONS. THE NETWORK ACCESS PLAN IS AVAILABLE AT THE PLAN'S OFFICE: 169 INVERNESS DRIVE W, SUITE 400, ENGLEWOOD, CO, 80112 OR CALL (800) 842-4509.