UnitedHealthcare

Intuit Inc; UHC Choice Network 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 800-381-8881. 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 833-993-0861 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $0 Non-Network: $0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No	See the Common Medical Events Chart below for your costs for services this plan covers.
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: $2,000.00 Individual / $6,000.00 Family per plan year For out-of-network providers: Not Covered Prescription Drugs - Network: $4,100.00 Individual* / $6,200.00 Family out-of-network: Not Covered *Doesn't apply if policy covers 2+ people	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, the overall family out-of-pocket limits must be 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 833-993-0861 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	$15.00 copay/visit	Not covered	Virtual visit – in-network - 0 coinsurance 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 co-insurance may apply.
	Specialist visit	$30.00 copay/visit	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)	
	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. Plan pays 100% for breast ultrasound and breast MRI as follow-up to inconclusive screening or to monitor when there is no cancer or illness diagnosis. Includes coverage of continuous glucose monitors and certain insulin products (i.e. Lancets, syringes, etc.)
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	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: $5.00 copay Mail Order: $10.00 copay	Retail: Not covered	Retail = 30 day supply; Mail Order = 90 days supply
	Preferred brand drugs (Tier 2)	Retail: $30.00 copay Mail Order: $60.00 copay	Retail: Not covered	Retail = 30 day supply; Mail Order = 90 days supply
	Non-preferred brand drugs (Tier 3)	Retail: $60.00 copay Mail Order: $120.00 copay	Retail: Not covered	Retail = 30 day supply; Mail Order = 90 days supply
	Specialty drugs (Tier 4)	Retail: N/A Mail Order: N/A	Retail: N/A Mail Order: N/A	Generic $5.00 copay, preferred brand $30.00 copay, non-preferred brand $60.00 copay. Specialty drugs must be filled through a CVS Specialty Pharmacy and have a 30-day limit.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$30.00 copay/visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$250.00 copay/visit	$250.00 copay/visit	None
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$40.00 copay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$150.00 copay/visit,	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, wellbeing, or substance use support	Outpatient services	No charge	Not covered	Your free mental health and wellbeing benefit is through Spring Health and includes 12 coaching and 12 counseling sessions per plan year as well as access to a comprehensive wellbeing platform/app. If you exhaust your 12 counseling sessions, you can continue your care with your health plan. Go to https://Intuit.SpringHealth.com or call (855)629-0554.
	Inpatient services	$150.00 copay/visit	Not covered	None
	Office visits	$15.00 copay/initial visit only	Not covered	Cost sharing does not apply for

If you are pregnant	Childbirth/delivery professional services	No charge	Not covered	preventive services. Depending on the type of service, a copayment,

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	$150.00 copay/visit	Not covered	coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound). In addition to your health plan coverage, you have access to virtual care and support through Maven go to http://mavenclinic.com/join/intuit
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Limited to 100 visits per plan year for Home Health Care. Limited to 100 visits per plan year for Private Duty Nursing. Covered beyond the 100-visit limit based on medical necessity
	Rehabilitation services	$30.00 copay/visit	Not covered	Limited to 60 visits each per plan year for Physical, Speech, Occupational Therapy.
	Habilitation services	Not covered	Not covered	Habilitation services are not covered.
	Skilled nursing care	$150.00 copay/visit	Not covered	Limited to 100 days per plan year
	Durable medical equipment	No charge	Not covered	DME replacement limited to once every 3 plan years.
	Hospice services	No charge	Not covered	None

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 • Long-term care	• Non-emergency care when traveling outside the U.S. • Routine Foot Care

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	• Hearing aids • Infertility treatment	• Private-duty nursing • 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/healthreformhttps://www.dol.gov/ebsa/healthreformhttps://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: 833-993-0861 or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/ebsa/healthreformwww.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 833-993-0861.

Traditional Chinese (中文): 如果需要中文的帮助，请拨打这个号码 833-993-0861.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 833-993-0861.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 833-993-0861 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-993-0861.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 833-993-0861.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 833-993-0861.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 833-993-0861.

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	$0.00
■ Specialist copayment	$30.00
■ Hospital (facility) copayment	$150.00
■ Other coinsurance	0%

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	$0.00
Copayments	$200.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	**$260.00**

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

■ The plan's overall deductible	$0.00
■ Specialist copayment	$30.00
■ Hospital (facility) copayment	$150.00
■ 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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$800.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$20.00
The total Joe would pay is	**$820.00**

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

■ The plan's overall deductible	$0.00
■ Specialist copayment	$30.00
■ Hospital (facility) copayment	$150.00
■ 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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$500.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$500.00**

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