



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at welcometouhc.com or by calling 1-888-567-4659.

| Important Questions | Answers | Why This Matters: |
|--|---|---|
| What is the overall <u>deductible</u>? | Network: \$1,000 Individual / \$2,000 Family Per calendar year. Copays, and services listed below as "No Charge" do not apply to the <u>deductible</u> . | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an <u>out-of-pocket limit</u> on my expenses? | Network: \$3,000 Individual / \$6,000 Family | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u>? | <u>Premium</u> , balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits. |
| Does this plan use a <u>network of providers</u>? | Yes. For a list of <u>network providers</u> , see myuhc.com or call 1-888-567-4659. | If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> . |
| Do I need a referral to see a <u>specialist</u>? | No. | You can see the <u>specialist</u> you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> . |

Questions: Call 1-888-567-4659 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf](https://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf) or call the phone number above to request a copy.

Summary of Benefits and Coverage: What This Plan Covers & What it Costs Coverage for: Employee & Family **Plan Type: EP1**



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan only covers services if rendered by network **providers**. Exceptions include emergency services as described in your policy.

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|--|--|---|---|--|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | UnitedHealth Premium Tier 1 Provider: \$20 copay per visit UnitedHealthcare Network Provider: \$40 copay per visit | Not Covered | Virtual visits (Telehealth) – \$10 copay per visit by a designated virtual network provider. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. |
| | Specialist visit | UnitedHealth Premium Tier 1 Provider: \$30 copay per visit UnitedHealthcare Network Provider: \$60 copay per visit | Not Covered | If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. |
| | Other practitioner office visit | \$30 copay per visit Airrosti: \$20 copay per visit | Not Covered | Cost share applies for only manipulative (chiropractic) services and is limited to 20 visits per calendar year. |
| | Preventive care / screening / immunization | No Charge | Not Covered | Includes preventive health services specified in the health care reform law. No coverage non-network. |
| If you have a test | Diagnostic test (x-ray, blood work) | No Charge | Not Covered | None |
| | Imaging (CT / PET scans, MRIs) | 20% co-ins after ded. | Not Covered | None |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|--|---|---|--|
| If you need drugs to treat your illness or condition (Retail 30-day supply) | Generic | \$15 | Not Covered | Coverage provided through Express Scripts. BIN#: 003858 PCN: A4 Group: FRISCOTX |
| | Preferred | \$25 | Not Covered | |
| | Non-Preferred | \$50 | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% co-ins after ded. | Not Covered | None |
| | Physician / surgeon fees | 20% co-ins after ded. | Not Covered | None |
| If you need immediate medical attention | Emergency room services | \$200 copay per visit | \$200 copay per visit | None |
| | Emergency medical transportation | 20% co-ins after ded. | *20% co-ins after ded. | *Network deductible applies |
| | Urgent care | \$60 copay per visit | Not Covered | If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% co-ins after ded. | Not Covered | None |
| | Physician / surgeon fees | 20% co-ins after ded. | Not Covered | None |
| If you have mental health, behavioral health, or substance abuse needs | Mental / Behavioral health outpatient services | \$20 copay per visit | Not Covered | None |
| | Mental / Behavioral health inpatient services | 20% co-ins after ded. | Not Covered | None |
| | Substance use disorder outpatient services | \$20 copay per visit | Not Covered | None |
| | Substance use disorder inpatient services | 20% co-ins after ded. | Not Covered | None |
| If you are pregnant | Prenatal and postnatal care | No Charge | Not Covered | Additional copays, deductibles, or co-ins may apply depending on services rendered. |
| | Delivery and all inpatient services | 20% co-ins after ded. | Not Covered | None |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---------------------------|---|---|--|
| If you need help recovering or have other special health needs | Home health care | 20% co-ins after ded. | Not Covered | Limited to 120 visits per calendar year. |
| | Rehabilitation services | \$30 copay per outpatient visit | Not Covered | Limits per calendar year: physical - 60 visits, speech - 52 visits, occupational – 52 visits; cardiac – unlimited visits; pulmonary – unlimited visits |
| | Habilitative services | \$30 copay per outpatient visit | Not Covered | Limits are combined with Rehabilitation Services limits listed above. |
| | Skilled nursing care | 20% co-ins after ded. | Not Covered | Limited to 60 days per calendar year. |
| | Durable medical equipment | 20% co-ins after ded. | Not Covered | Covers 1 per type of DME (including repair/replacement) every 3 years. |
| | Hospice service | 20% co-ins after ded. | Not Covered | None |
| If your child needs dental or eye care | Eye exam | Not Covered | Not Covered | No coverage for Eye Exams. |
| | Glasses | Not Covered | Not Covered | No coverage for glasses. |
| | Dental check-up | Not Covered | Not Covered | No coverage for dental check-up. |

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | | |
|---------------------|-----------------------------|--|----------------------------------|
| • Acupuncture | • Dental care (Adult/Child) | • Long-term care | • Routine eye care (Adult/Child) |
| • Bariatric surgery | • Glasses (Adult/Child) | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Cosmetic surgery | • Infertility treatment | | • Weight loss programs |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the 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.

Your Grievance and Appeals Rights:

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee & Family **Plan Type:** EP1

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-567-4659.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-567-4659.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-888-567-4659.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-567-4659.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*-----

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,440
- Patient pays \$2,100

Sample care costs:

| | |
|----------------------------|---------|
| Hospital charges (mother) | \$2,700 |
| Routine obstetric care | \$2,100 |
| Hospital charges (baby) | \$900 |
| Anesthesia | \$900 |
| Laboratory tests | \$500 |
| Prescriptions | \$200 |
| Radiology | \$200 |
| Vaccines, other preventive | \$40 |

Total \$7,540

Patient pays:

| | |
|----------------------|---------|
| Deductibles | \$1,000 |
| Copays | \$0 |
| Coinsurance | \$900 |
| Limits or exclusions | \$200 |

Total \$2,100

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$900
- Patient pays \$4,500

Sample care costs:

| | |
|--------------------------------|---------|
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures | \$700 |
| Education | \$300 |
| Laboratory tests | \$100 |
| Vaccines, other preventive | \$100 |

Total \$5,400

Patient pays:

| | |
|----------------------|---------|
| Deductibles | \$200 |
| Copays | \$100 |
| Coinsurance | \$0 |
| Limits or exclusions | \$4,200 |

Total \$4,500

Questions and answers about Coverage Examples:

| | | |
|---|---|---|
| <p>What are some of the assumptions behind the Coverage Examples?</p> <ul style="list-style-type: none"> • Costs don't include <u>premiums</u>. • Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan. • The patient's condition was not an excluded or preexisting condition. • All services and treatments started and ended in the same coverage period. • There are no other medical expenses for any member covered under this plan. • Out-of-pocket expenses are based only on treating the condition in the example. • The patient received all care from in-network <u>providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher. • If other than individual coverage, the Patient Pays amount may be more. | <p>What does a Coverage Example show?</p> <p>For each treatment situation, the Coverage Example helps you see how <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.</p> | <p>Can I use Coverage Examples to compare plans?</p> <p>✓ <u>Yes</u>. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.</p> |
| | <p>Does the Coverage Example predict my own care needs?</p> <p>✗ <u>No</u>. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.</p> | <p>Are there other costs I should consider when comparing plans?</p> <p>✓ <u>Yes</u>. An important cost is the <u>premium</u> you pay. Generally, the lower your <u>premium</u>, the more you'll pay in out-of-pocket costs, such as <u>copayments</u>, <u>deductibles</u>, and <u>coinsurance</u>. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.</p> |
| | <p>Does the Coverage Example predict my future expenses?</p> <p>✗ <u>No</u>. Coverage Examples are <u>not</u> cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your <u>providers</u> charge, and the reimbursement your health plan allows.</p> | |

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