UnitedHealthcare

Choice Plus PPO Plan

Coverage for: Family | **Plan Type:** POS

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 1-866-633-2446 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 Out-of-Network: **$10,000** Individual / **$20,000** 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 deductibles?	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. 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: **$6,000** Individual / **$12,000** Family Out-of-Network: **$20,000** Individual / **$40,000** 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 and penalties for failure to obtain preauthorization for services.	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 myuhc.com or call 1-866-633-2446 for a list of network providers.	You will pay the least if you use a provider in the Designated Network. You pay more if you use a provider in the 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	ServicesYouMayNeed	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 copay per visit, deductible does not apply	50% coinsurance	Under age 19 - Network visits are covered at No Charge. If you receive services in addition to office visit, additional copays or coinsurance may apply e.g. surgery.
	Specialist visit	Designated Network: $50 copay per visit, deductible does not apply Network: $100 copay per visit, deductible does not apply	50% coinsurance	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	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)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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	Tier 1 - Your Lowest Cost Option	$10 (Retail 30) $25 (Retail 90) $25 (Mail 1-90)	Not Covered.	Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at OptumRx.com or call Member Services at 1-800-765-6830 Specialty Member Services: 1-877-656-9604 Generic Policy - Dispense as Written (DAW) If a Brand name drug is filled when a Generic equivalent is available you will be required to pay the Brand cost share plus the difference in cost between the Generic and Brand name drug. The Generic Policy does not apply if the prescription indicates the Brand must be dispensed.
	Tier 2 - Your Mid-Range Cost Option	$35 (Retail 30) $87.50 (Retail 90) $87.50 (Mail 1-90)	Not Covered	
	Tier 3 - Your Mid-Range Cost Option	$70 (Retail 30) $175 (Retail 90) $175 (Mail 1-90)	Not Covered	
	Tier 4 - Your Highest Cost Option	$70 (Specialty 30)	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	20% 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 per visit, deductible does not apply	$300 copay per visit, deductible does not apply	None
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network deductible applies
	Urgent Care	$25 copay per visit, deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay per visit, deductible does not apply	50% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
If you are pregnant	Office Visits	No Charge	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	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.)

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	20% coinsurance	50% coinsurance	Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	$15 copay per visit, deductible does not apply	50% coinsurance	Limits per calendar year: Physical, Occupational, Speech, Pulmonary: 20 visits each; Cardiac: 36 visits. Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. Visit limits do not apply for the treatment of mental illness or substance-related & addictive disorders.
	Habilitative services	$15 copay per visit, deductible does not apply	50% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Durable medical equipment	20% coinsurance	50% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or no coverage.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
If your child needs dental or eyecare	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	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.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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.)		
• Acupuncture Services • Bariatric surgery • Cosmetic Surgery • Dental Care	• Glasses • Infertility Treatment • Long Term Care • Non-emergency care when traveling outside - the US	• Prescription drugs • Private duty nursing • Routine Eye Care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic (manipulative care) - 20 visits per calendar year	• Hearing aids - $2,500 per calendar year	• Routine foot care (covered for certain conditions)

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. Additionally, a consumer assistance program may help you file your appeal. Contact 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 1-866-633-2446.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-633-2446.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-633-2446 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2446.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2446.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-866-633-2446.

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

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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	**$50**
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	**$1600**
What isn't covered	
Limits or exclusions	**$70**
The total Peg would pay is	**$4,670**

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	**$50**
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	**$750**
Copayments	**$100**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$4,300**
The total Joe would pay is	**$5,150**

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

The plan's overall deductible	**$3,000**
Specialist copay	**$50**
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	**$1,300**
Copayments	**$400**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$10**
The total Mia would pay is	**$1,710**

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