UnitedHealthcare

Choice Plan 1000 - 90% / 30%

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.MyTHR.org or call 1-682-236-7236. 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 1-877-698-4754 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Designated Network: $1,000 Individual / $3,000 Family Network: $4,000.00 Individual / $12,000.00 Family Non-Network: Not Covered 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?	Designated Network: $6,850 Individual / $13,700 Family For network provider: $6,850 Individual / $13,700 Family per calendar year For out-of-network providers: Not Covered	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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-877-MYTHRLink 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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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	$20.00 copay/visit	$20.00 copay/visit	Not covered	Virtual Visit - In network $0 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	$40.00 copay/visit	$40.00 copay/visit	Not covered	If you receive services in addition to office visit, additional copays, deductibles, or co-insurance may apply
	Preventive care/screening/ immunization	No charge	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)	10% coinsurance	No charge if processed in doctor's office; 10% after deductible at freestanding network facility or 70% after deductible at a hospital that is not preferred	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)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	10% coinsurance	70% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.MyTHR.org	Generic Drugs (Tier 1)	Not covered	Not covered	Not covered	None
	Preferred brand drugs (Tier 2)	Not Covered	Not covered	Not covered	None
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	Not covered	None
	Specialty drugs (Tier 4)	Not covered	Not covered	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Office visit copay applies; 10% after deductible if not in doctor's office	Office visit copay applies; 10% after deductible at freestanding network facility or 70% after deductible at a hospital that is not preferred	Not covered	None
	Physician/ surgeon fees	10% coinsurance	10% after deductible at UHC Network Doctors or freestanding network facility or 70% after deductible at a	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)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			hospital that is not preferred		
If you need immediate medical attention	Emergency room care	$200.00 copay/visit, 10% coinsurance	$200.00 copay/visit, 10% coinsurance	$200.00 copay/visit, 10% coinsurance	None
	Emergency medical transportation	No charge	No charge	No charge	None
	Urgent care	$25.00 copay/visit	$25.00 copay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	70% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	70% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20.00 copay/visit	$20.00 copay/visit	Not covered	Partial Hospitalization/Intensive outpatient treatment In-network 10% co-ins after deductible for THR Preferred/UHC Choice Network
	Inpatient services	10% coinsurance	10% coinsurance	Not covered	None
If you are pregnant	Office visits	$20.00 copay/initial visit only	$20.00 copay/initial visit only	Not covered	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may
	Childbirth/delivery professional services	10% coinsurance	70% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	10% coinsurance	70% coinsurance	Not covered	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	10% coinsurance	10% coinsurance	Not covered	100 visits per calendar year, combined per person THR Preferred/UHC Choice Network
	Rehabilitation services	$20.00 copay/visit	$20.00 copay/visit	Not covered	60 visits combined per person for PT/Speech/OT 36 visits Cardiac. 20 visits/Pulmonary calendar year. Rehabilitation services with a primary behavioral health diagnosis: 10% coinsurance after deductible. Visits limits do not apply to members with a behavioral diagnosis. THR Preferred/UHC Choice Network
	Habilitation services	Not covered	Not covered	Not covered	Habilitation Services is not covered
	Skilled nursing care	10% coinsurance	10% coinsurance	Not covered	60 days per calendar year combined per person THR Preferred/UHC Choice Network
	Durable medical equipment	10% coinsurance	10% 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)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	10% coinsurance	10% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Child routine vision exam is not covered.
	Children's glasses	Not covered	Not covered	Not covered	Child glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Not covered	Child dental check-up is not covered.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

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. • Private-duty nursing	• 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 • Hearing aids	• Infertility treatment

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: 1-877-MYTHRLink or visit www.myuhc.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? No

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 1-877-MYTHRLink.

Traditional Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-MYTHRLink.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-MYTHRLink.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-877-MYTHRLink uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-MYTHRLink.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-877-MYTHRLink.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-MYTHRLink.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-877-MYTHRLink.

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**	**$4,000.00**
■ **Specialist copayment**	**$40.00**
■ **Hospital (facility) coinsurance**	**70%**
■ **Other coinsurance**	**70%**

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	$4,000.00
Copayments	$0.00
Coinsurance	$2,900.00
What isn't covered	
Limits or exclusions	$70.00
The total Peg would pay is	**$6,920.00**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$4,000.00**
■ **Specialist copayment**	**$40.00**
■ **Hospital (facility) coinsurance**	**70%**
■ **Other coinsurance**	**70%**

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	$100.00
Copayments	$200.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$4,300.00
The total Joe would pay is	**$4,600.00**

Mia's Simple Fracture

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

■ **The plan's overall deductible**	**$4,000.00**
■ **Specialist copayment**	**$40.00**
■ **Hospital (facility) coinsurance**	**70%**
■ **Other coinsurance**	**70%**

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	$1,100.00
Copayments	$200.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$10.00
The total Mia would pay is	**$1,310.00**