UnitedHealthcare

Choice Plus EFSZ MOD / EJ

Coverage For: Family | Plan Type: PS1

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 1-844-333-8728 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: **$4,000** Individual / **$8,000** Family Out-of-Network: **$5,000** Individual / **$10,000** 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 deductible?	Yes. Preventive care is 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: **$7,000** Individual / **$14,000** Family Out-of-Network: **$10,000** Individual / **$20,000** 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 www.myuhc.com or call **1-844-333-8728** 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	30% coinsurance	50% coinsurance	None
	Specialist visit	30% coinsurance	50% coinsurance	None
	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. *Certain non-network services are covered.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Testing: 30% coinsurance X-Ray/Diagnostics: Mammogram; additional diagnostic services and testing after a mammogram: No Charge Other x-rays and diagnostic testing: 30% coinsurance	Lab Testing: 50% coinsurance X-Ray/Diagnostics: Mammogram; additional diagnostic services and testing after a mammogram: No Charge Other x-rays and diagnostic testing: 50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	30% 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 More information about prescription drug coverage is available at welcometouhc.com	Tier 1 - Your Lowest Cost Option	Retail: $15 copay, deductible does not apply. Mail-Order: $37.50 copay, deductible does not apply.	Retail: $15 copay, deductible does not apply.	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. 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. Tier 1 Insulin is No Charge. Retail: Tier 2 Insulin is $15 per Prescription Order or Refill, deductible does not apply. Mail-Order: Tier 2 Insulin is $37.50 per Prescription Order or Refill, deductible does not apply. 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: $45 copay, deductible does not apply. Mail-Order: $112.50 copay, deductible does not apply.	Retail: $45 copay, deductible does not apply.	
	Tier 3 - Your Mid-Range Cost Option	Retail: $85 copay, deductible does not apply. Mail-Order: $212.50 copay, deductible does not apply.	Retail: $85 copay, deductible does not apply.	
	Tier 4 - Your Highest Cost Option	Retail: $200 copay, deductible does not apply. Mail-Order: $500 copay, deductible does not apply.	Retail: $200 copay, deductible does not apply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Physician/ surgeon fees	30% 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	30% coinsurance	*30% coinsurance	*Network deductible applies.
	Emergency medical transportation	30% coinsurance	*30% coinsurance	*Network deductible applies.
	Urgent Care	30% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Physician/ surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	Network All Other: 30% coinsurance. See your policy or plan document for additional information about Employee Assistance Program (EAP) benefits.
	Inpatient services	30% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No Charge	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	30% 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.)
	Childbirth/delivery facility services	30% 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.

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	30% 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	30% coinsurance	50% coinsurance	Limits per calendar year: Physical, Occupational, Speech: 52 visits each; Cardiac: 36 visits; Pulmonary: 20 visits. Out-of-network limits per calendar year: Physical, Occupational, Speech: 20 visits each
	Habilitative services	30% coinsurance	50% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	30% 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	30% 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	30% 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 eye care	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.

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
- Bariatric surgery
- Cosmetic Surgery
- Dental Care
- Glasses
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside - the US
- Private duty nursing
- Routine Eye Care
- 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.)

- Chiropractic (manipulative care) – Network: 52 visits per calendar year
- Hearing aids

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 Minnesota Department of Commerce at 1-800-657-3602 or http://mn.gov/commerce.

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 1-844-333-8728.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-333-8728.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-844-333-8728.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-333-8728.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-844-333-8728 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-844-333-8728.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-844-333-8728.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-844-333-8728.

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**
- **Specialist coinsurance** **30%**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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**
Copayments	**$10**
Coinsurance	**$2,100**
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$6,170**

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**
- **Specialist coinsurance** **30%**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	**$1,100**
Copayments	**$300**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$0**
The total Joe would pay is	**$1,400**

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

- **The plan's overall deductible** **$4,000**
- **Specialist coinsurance** **30%**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	**$2,790**
Copayments	**$10**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$2,800**

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