UnitedHealthcare

**Select Plus HSA Plan ECWQ Mod**

**Coverage For: Family | Plan Type: PPO**

**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 1-855-651-5944 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: **$1,650** Individual / **$3,300** Family<br>Out-of-Network: **$4,500** Individual / **$9,000** Family<br>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, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive Care Services 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.<br>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: **$3,000** Individual / **$6,000** Family<br>Out-of-Network: **$18,000** Individual / **$36,000** Family<br>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 1-855-651-5944 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 | 10% coinsurance | 50% coinsurance | Virtual Visits - 0% coinsurance by a Designated Virtual Network Provider. Office Visit cost share applies to any other Telehealth service based on provider type. No virtual coverage out-of-network. |
| | Specialist visit | 10% 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. No coverage out-of-network. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab Testing:<br>Free Standing/Office:<br>10% coinsurance<br>Hospital: 50% coinsurance<br>X-Ray/Diagnostics:<br>10% coinsurance | Lab Testing:<br>Not Covered<br>X-Ray/Diagnostics:<br>50% coinsurance | Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.<br>No coverage out-of- network for lab testing. |
| | Imaging (CT/PET scans, MRIs) | Free Standing/Office:<br>10% coinsurance<br>Hospital: 50% coinsurance | 50% coinsurance | Preauthorization is required out-of-network 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 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: $10 copay<br>Mail-Order: $25 copay<br>Specialty Retail: $10 copay | Retail: $10 copay<br>Specialty Retail: $10 copay | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 31 day supply.<br>Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy. Specialty drugs are not covered through mail order.<br>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.<br>Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge.<br>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.<br>Prescription drug costs are subject to the annual deductible. Network deductible will be applied to the out-of-network provider and applies to the Network out-of-pocket limit. |
| | Tier 2 - Your Mid-Range Cost Option | Retail: $35 copay<br>Mail-Order: $87.50 copay<br>Specialty Retail: $150 copay | Retail: $35 copay<br>Specialty Retail: $150 copay | |
| | Tier 3 - Your Mid-Range Cost Option | Retail: $70 copay<br>Mail-Order: $175 copay<br>Specialty Retail: $250 copay | Retail: $70 copay<br>Specialty Retail: $250 copay | |
| | Tier 4 - Your Highest Cost Option | Not Applicable | Not Applicable | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 50% coinsurance | Out-of-network allowed amounts for Facility Fees are limited to $760 per date of service.<br>Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. |
| | Physician/ surgeon fees | 10% 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 | 10% coinsurance | *10% coinsurance | *Network deductible applies. |
| | Emergency medical transportation | 10% coinsurance | *10% coinsurance | *Network deductible applies. |
| | Urgent Care | 10% coinsurance | 50% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 50% coinsurance | Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| | Physician/ surgeon fees | 10% coinsurance | 50% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 10% coinsurance | 50% coinsurance | Network All Other: 10% coinsurance.<br>See your policy or plan document for additional information about EAP benefits. |
| | Inpatient services | 10% 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 | 10% 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 | 10% 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 | 10% coinsurance | 50% coinsurance | Limited to 100 visits per calendar year. Out-of-network allowed amounts for Home health care are limited to $150 per visit.<br>Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| | Rehabilitation services | 10% coinsurance | 50% coinsurance | Outpatient rehabilitation services are unlimited per calendar year.<br>No limits apply for treatment of Autism Spectrum Disorder Services.<br>No coverage out-of-network for physical and occupational therapy. |
| | Habilitative services | 10% coinsurance | 50% coinsurance | Services are provided under Rehabilitation Services above.<br>No limits apply for treatment of Autism Spectrum Disorder Services.<br>No coverage out-of-network for physical and occupational therapy. |
| | Skilled nursing care | 10% coinsurance | 50% coinsurance | Skilled Nursing is limited to 100 days per calendar year.<br>Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| | Durable medical equipment | 10% coinsurance | Not covered | No coverage out-of-network. |
| | Hospice services | 10% 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. |

| 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 your child needs dental or eye care** | Children's eye exam | 10% coinsurance | Not covered | Limited to 1 exam every 24 months. No coverage out-of-network. |
| | 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.)**

- Cosmetic Surgery
- Dental Care
- Glasses
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside - the US
- Private duty nursing
- Routine foot care - Except as covered for Diabetes

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture - 20 visits per calendar year
- Bariatric surgery - 1 procedure per lifetime
- Chiropractic (manipulative) care - 24 visits per calendar year
- Hearing aids - $2,500 per calendar year
- Routine eye care (Adult) - 1 exam per 24 months
- Weight loss programs- Real Appeal

**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 Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov , or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://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: 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 Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov.

**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 1-855-651-5944.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-651-5944.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-855-651-5944.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-651-5944.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-855-651-5944 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-651-5944.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-651-5944.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-855-651-5944.

***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** **$1,650**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

**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 | **$1,650** |
| Copayments | **$10** |
| Coinsurance | **$1,000** |
| *What isn't covered* | |
| Limits or exclusions | **$60** |
| **The total Peg would pay is** | **$2,720** |

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

- **The plan's overall deductible** **$1,650**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

**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 | **$1,650** |
| Copayments | **$70** |
| Coinsurance | **$10** |
| *What isn't covered* | |
| Limits or exclusions | **$0** |
| **The total Joe would pay is** | **$1,730** |

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

- **The plan's overall deductible** **$1,650**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

**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 | **$1,650** |
| Copayments | **$10** |
| Coinsurance | **$100** |
| *What isn't covered* | |
| Limits or exclusions | **$0** |
| **The total Mia would pay is** | **$1,760** |

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