Realizing Student Success through Employee Engagement

Westside Human Resources

May 23, 2022

RE: Westside Community Schools Pre-65 Retiree Medical/Dental Coverage

Dear Westside Retiree,

You are receiving the enclosed information for 2022 Benefit Open Enrollment. The following link provides all plan documents for the 2022-23 Open Enrollment for Pre-65 Retirees

https://www.westside66.org/Page/699

There are three different medical plans offered this year. If you choose to continue participating in Westside Community Schools Pre-65 Insurances, you must complete an enrollment form with your chosen plan indicated. Forms must be back to Westside Human Resources by June 20, 2022. Please study the enclosed materials and choose the best option for you, and your dependents, if applicable.

You may mail your forms back to Westside Human Resources, 909 South 76th Street, Omaha, NE 68114. Be sure to fill out the entire form; Name, Social Security number, Date of Birth, Address, email address, all dependents to be covered, plan choice, sign and date.

If you have questions regarding plan options, you may email Westside Community Schools Human Resources Department at hrdept@westside66.net or call 402.390.2144.

Best Regards,

Westside Community Schools
Human Resources Department
hrdept@westside66.net

Administration Office
909 South 76th Street
Omaha, NE 68114
ph 402.390.2100
fax 402.408.8693
www.westside66.org

Pre-65 Enrollment/Change Form

Westside Community Schools

☐ Enroll
☐ Cancel Date: ___/___/___
☐ Change
☐ Name/Address Change

Email Address:

Social Security Number	Name *(last)* *(first)*	Date of Birth ___/___/____	Gender ❑ Male ❑ Female

Address *(street, PO Box)*	City	State	Zip	Home Phone ( )	Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

DEPENDENT INFORMATION

Last Name First Name MI	Gender	Relationship	Birth Date	Social Security Number
	☐ M ☐ F	Spouse		
	☐ M ☐ F	☐ Child ☐ Stepchild		
	☐ M ☐ F	☐ Child ☐ Stepchild		
	☐ M ☐ F	☐ Child ☐ Stepchild		
	☐ M ☐ F	☐ Child ☐ Stepchild		

COVERAGE SELECTION-MEDICAL	COVERAGE SELECTION – DENTAL
❑ $1,250 Deductible Plan ❑ $2,500 Deductible Plan ❑ $3,800 Deductible Plan	❑ Dental
❑ Employee Only ❑ Employee & Spouse ❑ Employee & Child(ren) ❑ Family ❑ Decline Medical Coverage	❑ Employee Only ❑ Employee & Spouse ❑ Employee & Child(ren) ❑ Family ❑ Decline Dental Coverage

CHANGE SECTION:
❑ Cancel Medical
❑ Cancel Dental

OTHER MEDICAL COVERAGE INFORMATION

On the day this coverage begins, will you, your spouse or any dependents be covered under any other medical health plan or policy, including another health plan or Medicare? ❑No (skip the rest of this section) ❑ Yes (continue completing this section)

❑ Name of Other Insurance Carrier_____
❑ Spouse's employer's plan ❑ Tri-Care
❑ Individual plan ❑ Medicare
❑ VA eligibility ❑ Medicaid
❑ COBRA ❑ I(we) have no other coverage ❑ Other_____

If Medicare: Name of Beneficiary

Medicare HIC#	Part A Effective Date: ___/___/____	Part B Effective Date ___/____/____

Reason for entitlement (check all applicable boxes) ❑ Age ❑ Disability ❑ End stage renal disease

OTHER DENTAL COVERAGE INFORMATION

On the day this coverage begins, will you, your spouse or any dependents be covered under any other dental plan or policy?

- ❑ Yes (continue completing this section) ❑No (skip the rest of this section)
- ❑ Name of Other Insurance Carrier_____
- ❑ Spouse's employer's plan
- ❑ Individual plan
- ❑ I(we) have no other coverage ❑ Other_____

AGREEMENT AND AUTHORIZATION
PLEASE READ THE FOLLOWING CAREFULLY

I represent the above information to be complete and accurate to the best of my knowledge. I understand that my answers to the questions contained in this enrollment form will be used to determine eligibility for coverage. I further understand that if any material information is omitted, it could provide the basis to refuse or rescind coverage.

I agree to the following terms for myself and anyone enrolled on or added to this application: We authorize, if permitted by law, health care providers, insurers, claim administrators and employers to provide medical, employment and benefit information, including information relating to drug, alcohol or psychiatric histories and treatment, to the insurance carrier on this enrollment form or their authorized representatives. Insurance carriers or their authorized representatives may share in such information and provide it to their insurers, claim administrators, insurers or other provider organizations only for the purpose of administering group coverage and claims for benefits, utilization review, analytical or research purposes, risk management, provider peer review or the resolution of grievances. I also authorize on behalf of myself and anyone enrolled or added to this application the use of Social Security Numbers for purposes of identification. I agree that a reproduced copy of this authorization will be as valid as the original.

I HAVE READ AND AGREE TO THE STATEMENTS ABOVE
(SIGNATURE REQUIRED BELOW)

X_____**X**_____
Signature **Date Signed**

WAIVER/DECLINE COVERAGE:

X_____**X**_____
Signature **Date Signed**

I have been given the opportunity to apply for group health coverage for myself and my dependents (if applicable)

If you are waiving/declining coverage for yourself or your dependents (including your spouse) because of other coverage, you or your dependents will not be able to enroll in the plan at a later time.

PRE-65 RETIREE

2022-2023

BENEFITS GUIDE

HEALTH • FINANCIAL • WORK-LIFE

September 1, 2022 - August 31, 2023

Welcome! Your benefits are an important part of your overall compensation. We are pleased to offer a comprehensive array of valuable benefits to protect your health, your family and your way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

Eligibility

A Pre-65 Retiree and/or Dependent of a Retiree must meet ALL of the following criteria:

1. The retiree is between the ages of 50-64;

AND

2. The retiree has worked in the Westside Community School District, or any other school district in Nebraska that is affiliated with the Educators Health Alliance AND covered under the Group Insurance plan for a minimum of 60 continuous months.

3. A dependent of an eligible Pre-65 Retiree that has been covered on the Pre-65 retiree plan for a period of no more than 4 years.

Eligible family members include:

- Your legally married spouse
- Your children who are your natural children, stepchildren, adopted children or children for whom you have legal custody who are under age 26. Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

When Coverage Begins

- **Open Enrollment:** Changes made during Open Enrollment are effective September 1, 2022 - August 31, 2023.

To enroll or make changes to your current elections, you will need to complete the Pre-65 Enrollment/Change Form. Changes include adding/dropping dependents or adding/dropping coverage. The Pre-65 Enrollment/Change Form is attached to the open enrollment email and is included in the open enrollment mailing.

Westside Community Schools

Required Information—*When you enroll, you will be required to enter a Social Security number (SSN) for all covered dependents. The Affordable Care Act (ACA), otherwise known as health care reform, requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.*

Medical

We are proud to offer you a choice of three medical plans through UnitedHealthcare. Following is a high-level overview of the coverage available.

Key Medical Benefits	Pre-65 $1,250 - PPO		Pre-65 $2,500 - PPO	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (per calendar year)				
Individual / Family	$1,250 / $2,500	$2,500 / $5,000	$2,500 / $5,000	$5,000 / $10,000
Out-of-Pocket Maximum (per calendar year)				
Individual / Family	$5,000 / $10,000	$9,600 / $19,200	$7,350 / $14,700	$14,700 / $29,400
Covered Services				
Office Visits (physician/specialist)	PCP: $35 copay /Specialist: Designated Network: $35 copay/ Network: $55 copay	40%*	PCP: $50 copay / Specialist: Designated Network: $50 copay/ Network: $70 copay	40%*
Routine Preventive Care	No charge	40%*	No charge	40%*
Outpatient Diagnostic (lab/X-ray)	No charge	40%*	No charge	40%*
Complex Imaging	20%*	40%*	30%*	40%*
Chiropractic	$35 copay up to 24 visits per calendar year	40%*, up to 24 visits per calendar year	30%*	40%*
Ambulance	20%*		30%*	
Emergency Room	$150 copay, then 20%		$100 copay, then 30%*	
Urgent Care Facility	$55 copay	40%*	$70 copay, then 30%*	40%*
Inpatient Hospital Stay	20%*	40%*	30%*	40%*
Outpatient Surgery	20%*	40%*	30%*	40%*
Prescription Drugs (Tier 1 / Tier 2 / Tier 3 / Tier 4)				
Retail Pharmacy (30-day supply)	$15 / $60 / $100 / $200		Tier 1: 30% coinsurance ($12 minimum/$45 maximum), Tier 2: 30% coinsurance ($55 minimum/$110 maximum), Tier 3: 30% coinsurance ($75 minimum/$150 maximum), Tier 4: 25% coinsurance ($125 minimum/$250 maximum)	60%*
Mail Order (90-day supply)	$45 / $180 / $300	No benefit	Tier 1: 30% coinsurance ($36 minimum/$135 maximum), Tier 2: 30% coinsurance ($165 minimum/$330 maximum), Tier 3: 50% coinsurance ($225 minimum/$450 maximum)	No benefit

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

Medical (continued)

We are proud to offer you a choice of three medical plans through UnitedHealthcare. Following is a high-level overview of the coverage available.

Key Medical Benefits	Pre-65 $3,800 - HSA	
	In-Network	Out-of-Network[1]
Deductible (per calendar year)		
Individual / Family	$3,800 / $7,600	$7,600 / $15,200
Out-of-Pocket Maximum (per calendar year)		
Individual / Family	$4,350 / $8,700	$13,000 / $26,000
Covered Services		
Office Visits (physician/specialist)	10%*	20%*
Routine Preventive Care	No charge	20%*
Outpatient Diagnostic (lab/X-ray)	10%*	20%*
Complex Imaging	10%*	20%*
Chiropractic	10%*	20%*
Ambulance	10%*	20%*
Emergency Room	10%*	
Urgent Care Facility	10%*	20%*
Inpatient Hospital Stay	10%*	20%*
Outpatient Surgery	10%*	20%*
Prescription Drugs (Tier 1 / Tier 2 / Tier 3 / Tier 4)		
Retail Pharmacy (30-day supply)	10%*	
Mail Order (90-day supply)	10%*	No benefit

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

Dental

We are proud to offer you a dental plan through UnitedHealthcare. Following is a high-level overview of the coverage available.

Key Dental Benefits	Dental Plan - DPPO	
	In-Network	Out-of-Network[1]
Deductible (per calendar year)		
Individual / Family	$25 / $25	$50 / $50
Benefit Maximum (per calendar year; preventive, basic, and major services combined)		
Per Individual	$5,000	
Covered Services		
Preventive Services	0%	30%
Basic Services	20%	30%*
Major Services	50%*	50%*
Orthodontia (Child Only)	$25 deductible, then 50% up to $1,000 Lifetime Maximum	$50 deductible, then 50% up to $1,000 Lifetime Maximum

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

Cost of Benefits

Your contributions toward the cost of benefits are on an after-tax basis. The amount will depend upon the plan you select and if you choose to cover eligible family members. **Please refer to the separate rate sheet for your contributions.**

Contact Information

Coverage	Carrier	Phone #	Website/Email
Medical	UnitedHealthcare	844-234-7921	myuhc.com
Dental	UnitedHealthcare	877-816-3596	www.myuhcdental.com

Questions?

If you have additional questions, you may also contact:

Human Resources
402-390-2144
hrdept@westside66.net

Westside Community Schools

Pre-65 Retiree Rates
Effective: September 1, 2022-August 31, 2023

MEDICAL COVERAGE

	Monthly Premium		
Coverage Tier	**$1,250 Plan**	**$2,500 Plan**	**$3,800 Plan**
Employee Only	**$1,026.64**	**$709.96**	**$709.96**
Employee + Spouse	**$2,155.96**	**$1,490.94**	**$1,490.94**
Employee + Child(ren)	**$1,899.34**	**$1,287.69**	**$1,287.69**
Family	**$2,894.90**	**$1,962.69**	**$1,962.69**

DENTAL COVERAGE

Coverage Tier	Monthly Premium
Employee Only	**$41.60**
Employee + Spouse	**$87.35**
Employee + Child(ren)	**$76.93**
Family	**$117.32**

United HealthCare Services, Inc. (20020)® Dental Plan

Contributory Options PPO 30 / covered dental services Custom/05P23/U90

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$25	$50	$25	$50
Family Annual Deductible	$25	$50	$25	$50
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)	$5,000 per person per Calendar Year	$5,000 per person per Calendar Year	$1,000 per person per Lifetime	$1,000 per person per Lifetime
New enrollee's waiting period	None			
Annual deductible applies to preventive and diagnostic services			No (In Network)	No (Out Network)
Annual Deductible Applies to Orthodontic Services			Yes	
Orthodontic Eligibility Requirement			Child Only (Up to Age 19)	

COVERED SERVICES *	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	70%	See Exclusions and Limitations section for benefit guidelines.
Radiographs	100%	70%	
Lab and Other Diagnostic Tests	100%	70%	
PREVENTIVE SERVICES			
Prophylaxis (Cleaning)	100%	70%	See Exclusions and Limitations section for benefit guidelines.
Fluoride Treatment (Preventive)	100%	70%	
Sealants	100%	70%	
Space Maintainers	100%	70%	
BASIC SERVICES			
Restorations (Amalgams or Composite)	80%	70%	See Exclusions and Limitations section for benefit guidelines.
Emergency Treatment/General Services	80%	70%	
Simple Extractions	80%	70%	
Oral Surgery (incl. surgical extractions)	80%	70%	
Periodontics	80%	70%	
Endodontics	80%	70%	
MAJOR SERVICES			
Inlays/Onlays/Crowns	50%	50%	See Exclusions and Limitations section for benefit guidelines.
Dentures and Removable Prosthetics	50%	50%	
Fixed Partial Dentures (Bridges)	50%	50%	
Implants	50%	50%	
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

**The network percentage of benefits is based on the discounted fees negotiated with the provider.

***The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage. Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

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 1-844-234-7921.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: **$1,250** Individual / **$2,500** Family Non-Network: **$2,500** Individual / **$5,000** 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 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 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: **$4,800** Individual / **$9,600** Family Non-Network: **$9,600** Individual / **$19,200** 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 **1-844-234-7921** for a list of network providers.	You 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	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	$35 copay per visit, deductible does not apply.	40% coinsurance	Virtual visits (Telehealth) - $20 copay per visit by a Designated Virtual Network Provider, deductible does not apply. No virtual coverage out-of-network If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	Designated Network: $35 copay per visit, deductible does not apply. Network: $55 copay per visit, deductible does not apply.	40% 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	40% 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)	No Charge	40% coinsurance	Preauthorization is required out-of-network for certain services.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization is required out-of-network.

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: $45 copay, deductible does not apply.	Retail: $15 copay, deductible does not apply.	Provider means pharmacy for purposes of this section. Retail: Up to a 90 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) are covered at No Charge. 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 4 includes specialty drugs.
	Tier 2 – Your Mid-Range Cost Option	Retail: $60 copay, deductible does not apply. Mail-Order: $180 copay, deductible does not apply.	Retail: $60 copay, deductible does not apply.	
	Tier 3 – Your Mid-Range Cost Option	Retail: $100 copay, deductible does not apply. Mail-Order: $300 copay, deductible does not apply.	Retail: $100 copay, deductible does not apply.	
	Tier 4 – Your Highest Cost Option	$200 copay, deductible does not apply.	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required out-of-network for certain services.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay per visit, then 20% coinsurance	$150 copay per visit, then 20% coinsurance	None
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network 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)	
	Urgent care	$55 copay per visit, deductible does not apply.	40% coinsurance	If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required out-of-network.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay per visit, deductible does not apply.	40% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance. Preauthorization is required out-of-network for certain services. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required out-of-network. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office visits	No Charge	40% coinsurance	Cost sharing does not apply for preventive services. 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 professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Inpatient preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours).
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network.
	Rehabilitation services	$35 copay per visit, deductible does not apply.	40% coinsurance	Limits per calendar year: Physical, Speech, Occupational, Pulmonary: 24 visits each; Cardiac: 36 visits

* 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)	
	Habilitative services	$35 copay per visit, deductible does not apply.	40% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. Preauthorization required out-of-network for certain services.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network.
	Durable medical equipment	20% coinsurance	40% 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	40% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility.
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 travelling outside - the U.S.
- 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) – 24 visits per calendar year
- Hearing aids - $2,500 per calendar year

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

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 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.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-844-234-7921.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-234-7921.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-234-7921.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-234-7921.

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	$1,250
Specialist copay	$55
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$55
Coinsurance	$2,299
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,664**

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

The plan's overall deductible	$1,250
Specialist copay	$55
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$120
Coinsurance	$1,206
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$2,606**

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

The plan's overall deductible	$1,250
Specialist copay	$55
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$150
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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

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 1-844-234-7921.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: **$2,500** Individual / **$5,000** Family Non-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 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 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: **$7,350** Individual / **$14,700** Family Non-Network: **$14,700** Individual / **$29,400** 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 **1-844-234-7921** for a list of network providers.	You 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	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	$50 copay per visit, deductible does not apply.	40% coinsurance	Virtual visits (Telehealth) - $20 copay per visit by a Designated Virtual Network Provider, deductible does not apply. No virtual coverage out-of-network If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	Designated Network: $50 copay per visit, deductible does not apply. Network: $70 copay per visit, deductible does not apply.	40% 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	40% 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)	No Charge	40% coinsurance	Preauthorization is required out-of-network for certain services.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	Preauthorization is required out-of-network.

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: 30% coinsurance ($12 min/$45 max), deductible does not apply. Mail-Order: 30% coinsurance ($36 min/$135 max), deductible does not apply.	Retail: 40% coinsurance	Provider means pharmacy for purposes of this section. Retail: Up to a 90 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) are covered at No Charge. 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 4 includes specialty drugs.
	Tier 2 – Your Mid-Range Cost Option	Retail: 30% coinsurance ($55 min/$110 max), deductible does not apply. Mail-Order: 30% coinsurance ($165 min/$330 max), deductible does not apply.	Retail: 40% coinsurance	
	Tier 3 – Your Mid-Range Cost Option	Retail: 30% coinsurance ($75 min/$150 max), deductible does not apply. Mail-Order: 50% coinsurance ($225 min/$450 max), deductible does not apply.	Retail: 40% coinsurance	
	Tier 4 – Your Highest Cost Option	Retail: 25% coinsurance ($125 min/$250 max), deductible does not apply.	Not Applicable	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	Preauthorization is required out-of-network for certain services.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay per visit then deductible, then 30% coinsurance	$100 copay per visit, then 30% coinsurance	None
	Emergency medical transportation	30% coinsurance	*30% coinsurance	*Network deductible applies
	Urgent care	$70 copay per visit, then deductible, then 30% coinsurance	40% coinsurance	If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	Preauthorization is required out-of-network.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay per visit, deductible does not apply.	40% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance. Preauthorization is required out-of-network for certain services. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	30% coinsurance	40% coinsurance	Preauthorization is required out-of-network. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office visits	No Charge	40% coinsurance	Cost sharing does not apply for preventive services. 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 professional services	30% coinsurance	40% coinsurance	

* 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)	
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	Inpatient preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours).
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network.
	Rehabilitation services	30% coinsurance	40% coinsurance	Limits per calendar year: Physical, Speech, Occupational combined 60 visits, Pulmonary and Cardiac: 18 visits each
	Habilitative services	30% coinsurance	40% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. Preauthorization required out-of-network for certain services.
	Skilled nursing care	30% coinsurance	40% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network.
	Durable medical equipment	30% coinsurance	40% 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	40% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility.
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 travelling outside - the U.S.
- 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) – 30 visits per calendar year
- Hearing aids - $2,500 per calendar year

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 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.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-234-7921.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-234-7921.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-234-7921.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-234-7921.

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	$2,500
Specialist copay	$70
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$70
Coinsurance	$3,075
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$5,645**

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

The plan's overall deductible	$2,500
Specialist copay	$70
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$140
Coinsurance	$1,428
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$4,098**

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

The plan's overall deductible	$2,500
Specialist copay	$70
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$140
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,940**

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

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 1-844-234-7921.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: **$3,800** Individual / **$7,600** Family Non-Network: **$7,600** Individual / **$15,200** 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 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: **$4,350** Individual / **$8,700** Family Non-Network: **$13,000** Individual / **$26,000** 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 **1-844-234-7921** 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	20% coinsurance	Virtual visits (Telehealth) - 0% coinsurance by a Designated Virtual Network Provider. No virtual coverage out-of-network
	Specialist visit	10% coinsurance	20% coinsurance	None
	Preventive care/screening/ immunization	No Charge	20% 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. Deductible is waived for Out-of-Network Childhood Immunizations for children under age 6.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	Preauthorization is required out-of-network for certain services.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	Preauthorization is required out-of-network.

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 & Mail: 10% Coinsurance	Retail: 10% Coinsurance	Provider means pharmacy for purposes of this section. Retail: Up to a 90 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) are covered at No Charge. 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. 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 & Mail: 10% Coinsurance	Retail: 10% Coinsurance	
	Tier 3 – Your Mid-Range Cost Option	Retail & Mail: 10% Coinsurance	Retail: 10% Coinsurance	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Preauthorization is required out-of-network for certain services.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
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

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)	
	Urgent care	10% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Preauthorization is required out-of-network.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 0% coinsurance. Preauthorization is required out-of-network for certain services. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	10% coinsurance	20% coinsurance	Preauthorization is required out-of-network. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	Cost sharing does not apply for preventive services. 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 professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	Inpatient preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours).
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network.
	Rehabilitation services	10% coinsurance	20% coinsurance	Limits per calendar year: Physical, Speech, Occupational combined 60 visits, Pulmonary and Cardiac: 18 visits each

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)	
	Habilitative services	10% coinsurance	20% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. Preauthorization required out-of-network for certain services.
	Skilled nursing care	10% coinsurance	20% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network.
	Durable medical equipment	10% coinsurance	20% 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	10% coinsurance	20% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility.
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 travelling outside - the U.S.
- 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) – 30 visits per calendar year
- Hearing aids - $2,500 per calendar year

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

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 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.
Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-844-234-7921.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-234-7921.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-234-7921.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-234-7921.

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	**$3,800**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,800
Copayments	$0
Coinsurance	$920
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,780**

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

The plan's overall deductible	**$3,800**
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,800
Copayments	$0
Coinsurance	$380
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$4,210**

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

The plan's overall deductible	**$3,800**
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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