United Healthcare

Attachment 2: Plan Design Summaries
FlexWork Limited MVP* "Edge Plan"

Benefit Category	FlexWork $0 Deductible Limited MVP "Edge Plan"
Actuarial Value - per Federal AV Calculator	60.60%
Deductible (Individual/Family)	No deductibles
Coinsurance	No coinsurance
Annual out-of-pocket max (Individual/Family)	$9,100 individual / $18,200 family for in-network services
Health care reform preventive medical service/medications	Covered at 100%
HealthiestYou™ Virtual Care	Covered at 100%, no annual visit limits
PCP and Specialist Physician Office/Telehealth Visits; Includes Prenatal and Post-Natal Care, Office Visits, Allergy Testing and Retail Health Clinic PCPs	6 visit limit per year (combined for PCP and Specialist) PCP visit: $25 copay; Specialist visit: $50 copay
Chiropractor and Acupuncture	$15 copay per visit 15 visit limit per year (combined for Chiropractor & Acupuncture)
Home Health Care	$80 copay per visit 30 visit limit per year
Rehabilitation and Habilitative Services (PT, OT, ST, Cardiac, Pulmonary)	$80 copay per visit 30 visit limit per year combined for rehabilitation + habilitative services
Skilled Nursing Care	Not covered
Durable Medical Equipment	Not covered
Hospice Services	Not covered
Outpatient Surgery: Facility + Professional	Office Visit: $500 copay; Outpatient Visit: $1,000 copay 1 visit limit per year
Diagnostic Tests (X-Ray, Blood Work)	Minor: Office Visit: $50 copay; Outpatient Visit: $150 copay 2 dates of service per year; unlimited tests per day (2 Major, 2 Minor)
Imaging (CT, PET, MRIs)	Major: Office Visit: $50 copay; Outpatient Visit: $150 copay 2 dates of service per year; unlimited tests per day
Emergency Room: Facility + Professional	$500 copay; 2 visit limit per year
Emergency Medical Transport	Not covered
Urgent Care: Facility + Professional	4 visit limit per year; $100 copay per visit
Hospital Services: Facility + Professional. Includes Inpatient Mental Health/Substance Use Disorder Services	$35,000 maximum benefit per admission $1,000 copay per admission. No annual admission limit
EAP Telephonic Support Line	$0 copay, no visit limit
Outpatient Mental Health/Substance Use - Partial Hospitalization Program / Intensive Outpatient Treatment	$150 copay per day PHP: 15 day limit per year; IOT: 15 day limit per year
Pharmacy Benefit	Copays - Tier 1: $15; Tier 2: $30; Tier 3 and 4: 50% coinsurance Retail only at UHC network pharmacies; no mail order
Prescription Drug List	FlexWork Limited Prescription Drug List

*Plan includes 125% Aggregate Stoploss corridor and a $125,000 Individual Stoploss deductible

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit us at flexwork.uhc.com or by calling 855-892-2401. 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 https://www.healthcare.gov/sbc-glossary/ or call 855-892-2401 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copayment are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing. 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 Providers: $9,100 individual / $18,200 family	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, healthcare this plan doesn't cover, charges exceeding allowed amount, and allowed amounts exceeding plan limits.	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 flexwork.uhc.com or call 855-892-2401 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	$25 copay/visit	Not Covered	6 office visit limit/year, combined sickness, injury, mental health, substance abuse services, pregnancy and specialist visits. Members can also receive limited care via HealthiestYou Telehealth Services consultations.
	Specialist visit	$50 copay/visit	Not Covered	
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive, then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay/day for free standing facility/doctor's office, and $150 copay/day for hospital outpatient	Not Covered	Limit of 2 days of service/year for diagnostic testing, regardless of setting. Technical and professional fees are covered for an unlimited number of tests when provided on the same day.
	Imaging (CT/PET scans, MRIs)	$50 copay/day for free standing facility/doctor's office, and $150 copay/day for hospital outpatient	Not Covered	Limit of 2 days of service/year for imaging, regardless of setting. Technical and professional fess are covered for an unlimited number of tests when provided on the same day.
If you need drugs to treat your illness or condition	Tier 1 drugs	$15 copay/retail prescription, Mail-order not covered	Not Covered	Provider means pharmacy for purposes of this section. Covers up to a 30-day supply for retail pharmacies. Specialty drugs are not covered. Utilize pharmacies in the Standard Select Network. Certain preventive medications (including certain contraceptives) are covered at No Charge.

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)	
More information about **prescription drug coverage** is available at flexwork.uhc.com	Tier 2 drugs	$30 copay/retail prescription. Mail-order not covered.	Not Covered	Certain drugs may have a preauthorization requirement or may result in a higher cost. 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. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copayment and/or coinsurance may be applied.
	Tier 3 drugs	50% coinsurance, Mail-order not covered.	Not Covered	
	Tier 4 drugs	50% coinsurance, Mail-order not covered.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay/surgery in free standing facility. $1000 copay/surgery in hospital outpatient.	Not Covered	Limit of 1 outpatient surgery/year. Copayment includes both facility and physician/surgeon fees.
	Physician/surgeon fees	$500 copay/free standing facility. $1000 copay/hospital outpatient.	Not Covered	
If you need immediate medical attention	Emergency room care	$500 copay/visit, includes facility and physician fees.	$500 copay/visit, includes facility and physician fees.**	2 visit limit/year. Copayment includes both facility and physician fees. **Out-of-Network emergency services are covered at the network benefit level.
	Emergency medical transportation	Not Covered	Not Covered	None
	Urgent Care	$100 copay/visit includes facility and physician fees.	Not Covered	4 visit limit/year. Lab, x-rays, diagnostic testing and imaging are not included in benefit for urgent care and are subject to applicable benefit for diagnostic testing and imaging.

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 a hospital stay	Facility fee (e.g., hospital room)	$1000 copay/admission, includes facility and physician fees.	Not Covered	$35,000 limit/admission. No Annual Visit limit. Unlimited admissions per plan year.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Primary care: $25 copay/visit Specialist: $50 copay/visit Partial hospitalization program/intensive outpatient treatment: $150 copay per day	Not Covered	6 office visit limit/year, combined sickness, injury, mental health, substance abuse services, pregnancy and specialist visits. 15 day limit/year for combine partial hospitalization program / and intensive outpatient treatment.
	Inpatient services	$1000 copay/admission, including facility and physician fees.	Not Covered	$35,000 limit/admission. No Annual Visit limit. Unlimited admissions per plan year.
If you are pregnant	Office visits	Primary Care: $25 copay/visit Specialist: $50 copay/visit	Not Covered	6 office visit limit/year, combined sickness, injury, mental health, substance abuse services, pregnancy and specialist visits. Cost sharing does not apply for Health Care Reform preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e ultrasound).
	Childbirth/delivery professional services	$1000 copay/admission, including facility and physician fees.	Not Covered	$35,000 limit
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	$80 copay/visit	Not Covered	Limited to 30 visits per year.
	Rehabilitation services	$80 copay/visit	Not Covered	30 combined visits per year for rehabilitation and habilitation services. Includes physical therapy, speech therapy and occupational therapy.
	Habilitation services	$80 copay/visit	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	Not Covered	Not Covered	None
	Durable medical equipment	Not Covered	Not Covered	None
	Hospice services	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- Bariatric surgery
- Children's eye exam
- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (adult)
- Durable medical equipment
- Emergency medical transportation
- Hearing aids
- Hospice services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- Skilled nursing care, and
- Weight-loss programs

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

- Acupuncture – 15 visits/year for combined acupuncture and chiropractic visits, $15 copay per visit.
- Chiropractic Care – 15 visits/year for combined acupuncture and chiropractic visits, $15 copay per visit.

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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: UnitedHealthcare FlexWork at 855-892-2401, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Insurance Department at 877-881-6388 or visit https://www.insurance.pa.gov/Consumers/Pages/default.aspx.

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 1-855-892-2401.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-855-892-2401.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-892-2401.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-855-892-2401 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-892-2401.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-892-2401.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-892-2401.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-855-892-2401.

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** $0
- **Specialist copayment** $50
- **Hospital (facility) copayment** $1,000
- **Other coinsurance** 0%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$400
The total Peg would pay is	$1,600

Managing Joe's type 2 Diabetes

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

- **The plan's overall deductible:** $0
- **Specialist copayment** $50
- **Hospital (facility) copayment** $1,000
- **Other coinsurance** 0%

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	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Joe would pay is	$1,000

Mia's Simple fracture

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

- **The plan's overall deductible:** $0
- **Specialist copayment** $50
- **Hospital (facility) copayment** $1,000
- **Other coinsurance** 0%

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	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,000
The total Mia would pay is	$1,800

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