



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 <u>deductible</u>?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> and categories with a <u>copayment</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible amount</u> . But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Network Providers</u> : \$9,100 individual / \$18,200 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , balance-billing charges, healthcare this <u>plan</u> doesn't cover, charges exceeding <u>allowed amount</u> , and <u>allowed amounts</u> exceeding <u>plan</u> limits.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See flexwork.uhc.com or call 855-892-2401 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>copay</u> /visit	Not Covered	6 office visit limit/year, combined sickness, injury, mental health, substance abuse services, pregnancy and <u>specialist</u> visits. Members can also receive limited care via HealthiestYou Telehealth Services consultations.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	Not Covered	
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$50 <u>copay</u> /day for free standing facility/doctor's office, and \$150 <u>copay</u> /day for hospital outpatient	Not Covered	Limit of 2 days of service/year for <u>diagnostic testing</u> , 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 <u>copay</u> /day for free standing facility/doctor's office, and \$150 <u>copay</u> /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 <u>copay</u> /retail prescription, Mail-order not covered	Not Covered	<u>Provider</u> means pharmacy for purposes of this section. Covers up to a 30-day supply for retail pharmacies. <u>Specialty drugs</u> 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 <u>copay</u> /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 <u>plan</u> . 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 <u>copayment</u> and/or <u>coinsurance</u> may be applied.
	Tier 3 drugs	50% <u>coinsurance</u> , Mail-order not covered.	Not Covered	
	Tier 4 drugs	50% <u>coinsurance</u> , Mail-order not covered.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 <u>copay</u> /surgery in free standing facility. \$1000 <u>copay</u> /surgery in hospital outpatient.	Not Covered	Limit of 1 outpatient surgery/year. <u>Copayment</u> includes both facility and physician/surgeon fees.
	Physician/surgeon fees	\$500 <u>copay</u> /free standing facility. \$1000 <u>copay</u> /hospital outpatient.	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$500 <u>copay</u> /visit, includes facility and physician fees.	\$500 <u>copay</u> /visit, includes facility and physician fees.**	2 visit limit/year. <u>Copayment</u> includes both facility and physician fees. **Out-of- <u>Network</u> emergency services are covered at the <u>network</u> benefit level.
	<u>Emergency medical transportation</u>	Not Covered	Not Covered	None
	<u>Urgent Care</u>	\$100 <u>copay</u> /visit includes facility and physician fees.	Not Covered	4 visit limit/year. Lab, x-rays, <u>diagnostic testing</u> and imaging are not included in benefit for <u>urgent care</u> and are subject to applicable benefit for <u>diagnostic testing</u> 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 <u>copay</u> /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	<u>Primary care</u> : \$25 <u>copay</u> /visit <u>Specialist</u> : \$50 <u>copay</u> /visit Partial hospitalization program/intensive outpatient treatment: \$150 <u>copay</u> per day	Not Covered	6 office visit limit/year, combined sickness, injury, mental health, substance abuse services, pregnancy and <u>specialist visits</u> . 15 day limit/year for combine partial hospitalization program / and intensive outpatient treatment.
	Inpatient services	\$1000 <u>copay</u> /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	<u>Primary Care</u> : \$25 <u>copay</u> /visit <u>Specialist</u> : \$50 <u>copay</u> /visit	Not Covered	6 office visit limit/year, combined sickness, injury, mental health, substance abuse services, pregnancy and <u>specialist visits</u> . <u>Cost sharing</u> does not apply for Health Care Reform <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e ultrasound).
	Childbirth/delivery professional services	\$1000 <u>copay</u> /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	<u>Home health care</u>	\$80 <u>copay</u> /visit	Not Covered	Limited to 30 visits per year.
	<u>Rehabilitation services</u>	\$80 <u>copay</u> /visit	Not Covered	30 combined visits per year for <u>rehabilitation</u> and <u>habilitation</u> services. Includes physical therapy, speech therapy and occupational therapy.
	<u>Habilitation services</u>	\$80 <u>copay</u> /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)	
	<u>Skilled nursing care</u>	Not Covered	Not Covered	None
	<u>Durable medical equipment</u>	Not Covered	Not Covered	None
	<u>Hospice services</u>	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): 如果需要中文的帮助, 请拨打这个号码 1-855-892-2401.

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

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, 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, a'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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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
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In this example, Joe would pay

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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
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In this example, Mia would pay

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$1,000
The total Mia would pay is	\$1,800