UnitedHealthcare®

Out of Area Standard PPO B

Coverage Period: 01/01/2014 – 12/31/2014

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for: Employee & Family** **Plan Type: PP1**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-800-964-8826.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$300** Individual / **$600** Family Non-Network: **$300** Individual / **$600** Family Per calendar year. Copays, prescription drugs, and services listed below as "No Charge" do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the Common Medical Events chart for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No. There are no other **deductibles**.	You don't have to meet **deductibles** for specific services, but see the Common Medical Events chart for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Network: **$2,300** per person Non-Network: **$2,300** per person	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover, prescription drug costs and penalties for failure to obtain Pre-Notification for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The Common Medical Events chart describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses network **providers**. If you use a non-network **provider** your cost may be more. For a list of network **providers**, see **www.myuhc.com** or call **1-800-382-4264** for a list of network **providers**. See www.caremark.com for a list of pharmacy providers.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network**. See the Common Medical Events chart for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed under Services Your Plan Does NOT Cover. See your policy or plan document for additional information about **excluded services**.

- **Co-payments (copays)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- Your costs for network providers will be lower than non-network **providers**.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	$15 copay per visit	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$30 copay per visit	$30 copay per visit	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	10% co-ins after ded. for Manipulative (Spinal) Services	10% co-ins after ded.for Manipulative (Spinal) Services	Benefits include diagnosis and related services and are limited to one visit and treatment per day up to 35 consecutive days per condition. Treatment will be reviewed for medical necessity after 35 consecutive days.
	Preventive care / screening / immunization	No Charge	No Charge	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-ins after ded.	10% co-ins after ded.	None
	Imaging (CT / PET scans, MRIs)	10% co-ins after ded.	10% co-ins after ded.	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Tier 1 – Your Lowest-Cost Option	$5 copay	$5 copay	Mail Order: $10 copay
	Tier 2 – Your Midrange-Cost Option	20% coinsurance ($30 min. $60 max. copay)	20% coinsurance ($30 min. $60 max. copay)	Mail Order: 20% coinsurance ($60 min. $120 max. copay)
	Tier 3 – Your Highest-Cost Option	30% coinsurance ($60 min. $100 max. copay)	30% coinsurance ($60 min. $100 max. copay)	Mail Order: 30% coinsurance ($120 min. $175 max. copay)

	Tier 4 – Additional High-Cost Options	Specialty Drugs covered at Tier 2 or Tier 3 coinsurance/copays as applicable	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins after ded.	10% co-ins after ded.	None
	Physician / surgeon fees	10% co-ins after ded.	10% co-ins after ded.	None
If you need immediate medical attention	Emergency room services	$75 copay per visit, then 10% co-ins after ded.	$75 copay per visit, then 10% co-ins after ded.	Copay is waived if you are admitted for Inpatient stay directly from the Emergency Room. Notification is required if confined in a Hospital.
	Emergency medical transportation	10% co-ins after ded.	10% co-ins after ded.	None
	Urgent care	10% co-ins after ded.	10% co-ins after ded.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay per Inpatient Stay, then 10% co-ins after ded.	$250 copay per Inpatient Stay, then 10% co-ins after ded.	Pre-Notification is required or benefit reduces to 50% of eligible expenses.
	Physician / surgeon fees	10% co-ins after ded.	10% co-ins after ded.	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	10% co-ins after ded.	10% co-ins after ded.	None
	Mental / Behavioral health inpatient services	$250 copay per Inpatient Stay, then 10% co-ins after ded.	$250 copay per Inpatient Stay, then 10% co-ins after ded.	None
	Substance use disorder outpatient services	10% co-ins after ded.	10% co-ins after ded.	None
	Substance use disorder inpatient services	$250 copay per Inpatient Stay, then 10% co-ins after ded.	$250 copay per Inpatient Stay, then 10% co-ins after ded.	None
If you become pregnant	Prenatal and postnatal care	$15 copay per visit	$15 copay per visit	Additional copays, deductibles, or co-ins may apply depending on services rendered. Your cost in this category includes Physician Delivery Charges. Routine pre-natal care is covered at No Charge.

	Delivery and all inpatient services	$250 copay per Inpatient Stay, then 10% co-ins after ded.	$250 copay per Inpatient Stay, then 10% co-ins after ded.	Your cost for inpatient services only. Delivery see above. Inpatient Pre-Notification may apply or benefit reduces to 50% of eligible expenses.
If you need help recovering or have other special health needs	Home health care	0% co-ins after ded.	0% co-ins after ded.	Limited to 40 visits per calendar year. Pre-Notification is required or benefit reduces to 50% of eligible expenses.
	Rehabilitation services	10% co-ins after ded.	10% co-ins after ded.	None
	Habilitative services	10% co-ins after ded.	10% co-ins after ded.	None
	Skilled nursing care	0% co-ins after ded.	0% co-ins after ded.	Limited to 60 days per calendar year. (combined with Inpatient Rehabilitation). Pre-Notification is required or benefit reduces to 50% of eligible expenses.
	Durable medical equipment	10% co-ins after ded.	10% co-ins after ded.	Pre-Notification is required for DME over $1,000.
	Hospice service	0% co-ins after ded.	0% co-ins after ded.	Inpatient Pre-Notification is required for non-network or benefit reduces to 50% of eligible expenses.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No coverage for Eye Exams.
	Glasses	Not Covered	Not Covered	No coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)			
• Cosmetic surgery • Dental care (Adult/Child)	• Glasses (Adult/Child) • Long-term care	• Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult/Child) • Routine foot care • Weight loss Programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)			
• Acupuncture • Bariatric Surgery, if member covered on plan for at least two years • Chiropractic care – limitations may apply	• Habilitative services – limitations may apply	• Hearing aids – limitations may apply	• Infertility treatment – limitations may apply • Private Duty Nursing (outpatient basis)

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-964-8826. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit http://www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can your human resources department or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-382-4264.
如果需要中文的帮助，请拨打这个号码 1-800-382-4264.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-382-4264.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-382-4264.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page*.----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- ☐ **Amount owed to providers:** $7,540
- ☐ **Plan Pays** $6,330
- ☐ **Patient Pays** $1,210

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Co-pays	$280
Co-insurance	$480
Limits or exclusions	$150
Total	**$1,210**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- ☐ **Amount owed to providers:** $5,400
- ☐ **Plan Pays** $4,400
- ☐ **Patient Pays** $1,000

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Co-pays	$500
Co-insurance	$120
Limits or exclusions	$80
Total	**$1,000**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

× **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

× **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-964-8826 or visit www.myuhc.com. If you aren't clear about any of the terms used in this form, see the Glossary.
You can view the Glossary at www.dol.gov/ebsa/healthreform or call the phone number above to request a copy. **This is only a summary**.
It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.