UnitedHealthcare®
Choice Plus Plan Set 014

Value PPO Plan

Coverage Period: 01/01/2015 –12/31/2015

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for: Employee + Family** **Plan Type: PS1**

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 **1-888-350-5607**.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$725** Individual / **$1,450** Family Non-Network: **$1,225** Individual / **$2,450** Family Does not apply to copays, and services listed below as "No Charge". Per calendar year.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. (Your deductible starts on January 1st of each year). See the chart starting on page 2 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: **$3,100** Individual / **$6,200** Family Non-Network: **$6,200** Individual / **$12,400** Family	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, and penalties for failure to obtain pre-notification for services and copays.	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 **1-888-350-5607** for a list of network 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 chart starting on page 2 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, $25) 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.)
- This plan may encourage you to use network providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	50% co-ins	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$35 copay per visit	50% co-ins	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$35 copay per visit of Manipulative (Chiropractic) services	50% co-ins per visit of Manipulative (Chiropractic) services	Limited to 12 visits of Manipulative (Chiropractic) in-network services or 6 non-network per calendar year (maximum of 12 visits combined). Pre-Notification required non-network.
	Preventive care / screening / immunization	$25 copay per visit	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins	50% co-ins	None
	Imaging (CT / PET scans, MRIs)	20% co-ins	50% co-ins	None
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest-Cost Option	Retail: Tier 1 – 10% of eligible expenses ($15 min/ $25 max) Mail-Order: 10% of eligible expenses ($25 min / $45 max)	Retail: Not Covered Mail-Order: Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply You may need to obtain certain drugs,

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
More information about prescription drug coverage is available at **www.myuhc.com**	Tier 2 – Your Midrange-Cost Option	Retail: 20% of eligible expenses ($30 min / $55 max) Mail-Order: 20% of eligible expenses ($60 min / $110 max)	Retail: Not Covered Mail-Order: Not Covered	including certain specialty drugs, from a pharmacy designated by us Certain drugs may have a pre-notification requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 3 – Your Highest-Cost Option	Retail: 40% of eligible expenses ($60 min / $85 max) Mail-Order: – 40% of eligible expenses ($120 min / $170 max)	Retail: Not Covered Mail-Order: Not Covered	
	Tier 4 – Additional High-Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins	50% co-ins	Pre-Notification required non-network.
	Physician / surgeon fees	20% co-ins	50% co-ins	None
If you need immediate medical attention	Emergency room services	True Emergency: $90 copay per visit then 20% of eligible expenses. Non-Emergency: $140 copay per visit then 20% of eligible expenses	True Emergency: $90 copay per visit then 20% of eligible expenses. Non-Emergency: $140 copay per visit then 50% of eligible expenses	You must call Care Coordination within 24 hours of admission.
	Emergency medical transportation	20% co-ins	20% co-ins	None
	Urgent care	$35 copay per visit	50% co-ins	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins	50% co-ins	Pre-Notification required non-network.
	Physician / surgeon fees	20% co-ins	50% co-ins	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	$50 copay per visit	50% co-insurance	Must have prior authorization through the Mental Health/Substance Abuse Designee 1 (800) 888-2998
	Mental / Behavioral health inpatient services	20% co-ins	50% co-ins	Must have prior authorization through the Mental Health/Substance Abuse Designee 1 (800) 888-2998
	Substance use disorder outpatient services	$25 copay per visit	50% co-ins	Must have prior authorization through the Mental Health/Substance Abuse Designee 1 (800) 888-2998
	Substance use disorder inpatient services	20% co-ins	50% co-ins	Must have prior authorization through the Mental Health/Substance Abuse Designee 1 (800) 888-2998
If you become pregnant	Prenatal and postnatal care	$25 Global Maternity copay	50% co-ins	Additional copays, deductibles, or co-ins may apply. Routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	20% co-ins	50% co-ins	Additional copays, deductibles, co-ins and inpatient Notification may apply.
If you have a recovery or other special health needs	Home health care	20% co-ins	50% co-ins	Services provided in the home by an RN, LPN or contracted therapist.** 130 day limit per calendar year (combined network/non-network.
	Rehabilitation services	20% co-ins	50% co-ins	Short-term physical, occupational, speech, cardiac and pulmonary therapies.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation services.
	Skilled nursing care	20% co-ins	50% co-ins	Confinement for skilled nursing services in a hospital or specialized facility. 120 days per calendar year limit

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
	Durable medical equipment	20% co-ins	40% co-ins	Replacement is limited to one type of equipment once every 3 calendar years.
	Hospice service	20% co-ins	50% co-ins	Limited to $5,000 Lifetime Maximum.
If your child needs dental or eye care	Eye exam	Not Covered.	Not Covered	No Coverage for Eye Exam.
	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.)		
• Acupuncture • Cosmetic Surgery • Dental Care (Adult/Child)	• Glasses • Habilitation Services • Hearing aids • Long-term care	• Private-duty nursing • Routine foot care • Routine eye care (Adult or Child) • 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.)		
• Bariatric Surgery	• Infertility Treatment	Non-emergency care when traveling outside the U.S.

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 1-866-747-1019. 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 Appeal 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 contact the Member Service number listed on the back of your ID card 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.

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.
若需要中文协助，请拨打您会员卡上的电话号码
Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih
Para sa tulong sa Tagalog, tawagan ang numero sa iyong

----------*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** $ 5,515
- **Patient Pays** $2,025

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	$725
Co-pays	$100
Co-insurance	$1,000
Limits or exclusions	$200
Total	**$2,025**

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

- **Amount owed to providers:** $5,400
- **Plan Pays** $3,895
- **Patient Pays** $1,505

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	$725
Co-pays	$300
Co-insurance	$400
Limits or exclusions	$80
Total	**$1,505**

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 **1-888-350-5607** or visit us at 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.