UnitedHealthcare

Nexus ACO OAP BY6K Mod / BX

Coverag e for: Family | **Plan Type:** PS1

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 1-888-331-3408 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: **$1,500** Individual / **$4,500** Family Out-of-Netw ork : **$3,000** Individual / **$9,000** 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 member s meets the overall family deduc tible.
Are there services covered before you meet your deductibles?	Yes. Preventive Care Services 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 preventive services at www.healthcare.gov/cov erage/preventiv e-care-benefits/.
Are there other deduct ibles 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: **$5,000** Individual / **$10,000** Family Out-of-Netw ork : **$9,000** Individu al / **$18,000** Family Per calendar year.	The out-of-pock et 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-pock et limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call 1-888-331-3408 for a list of network providers.	You will 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 differenc e 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	Designated Network: $15 copay per visit, deductible does not apply Network: $30 copay per visit, deductible does not apply	50% coinsurance	Virtual Visits - $10 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: $45 copay per visit, deductible does not apply Network: $70 copay per visit, deductible does not apply	50% 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	Not covered	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. No coverage out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Lab Testing: Not covered X-Ray/Diagnostics: 50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. No coverage out-of-network for lab testing.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.

*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)	
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: $10 copay, deductible does not apply Mail-Order: $30 copay, deductible does not apply	Retail: $10 copay, deductible does not apply	Provider means pharmacy for purposes of this section. Retail: Up to a 31 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 2 - Your Mid-Range Cost Option	Retail: $35 copay, deductible does not apply Mail-Order: $105 copay, deductible does not apply	Retail: $35 copay, deductible does not apply	
	Tier 3 - Your Mid-Range Cost Option	Retail: $70 copay, deductible does not apply Mail-Order: $210 copay, deductible does not apply	Retail: $70 copay, deductible does not apply	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Designated Network: 20% coinsurance Network: 40% coinsurance	50% coinsurance	$250 per occurrence deductible applies prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	Designated Network: 20% coinsurance Network: 40% coinsurance	50% coinsurance	None

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 immediate medical attention	Emergency room care	20% coinsurance	*20% coinsurance	*Network deductible applies.
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network deductible applies.
	Urgent Care	$45 copay per visit, deductible does not apply	50% 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)	Designated Network: 20% coinsurance Network: 40% coinsurance	50% coinsurance	$500 per occurrence deductible applies prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	Designated Network: 20% coinsurance Network: 40% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay per visit, deductible does not apply	50% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance. Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No Charge	50% coinsurance	Cost sharing does not apply for preventive services.

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

	Childbirth/delivery professional services	Designated Network: 20% coinsurance Network: 40% coinsurance	50% coinsurance	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.).

*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	Designated Network: 20% coinsurance Network: 40% coinsurance	50% coinsurance	$500 hospital per occurrence deductible applies prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	$15 copay per visit, deductible does not apply	50% coinsurance	Limits per calendar year: Cardiac: 36 visits; Pulmonary : 20 visits; Physical, Occupational, Speech: Unlimited.
	Habilitative services	$15 copay per visit, deductible does not apply	50% coinsurance	Services are provided under Rehabilitation Services above. No limits apply for treatment of Autism Spectrum Disorder Services.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Durable medical equipment	20% coinsurance	Not covered	Covers 1 per type of DME (including repair/replacement) every 3 years. No coverage out-of-network.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
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.

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

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 • Cosmetic Surgery • Dental Care • Glasses	• Infertility Treatment • Long Term Care • Non-emergency care when traveling outside the US	• 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.)		
• Acupuncture Services - 12 visits per calendar year	• Chiropractic (manipulative care)	• Hearing aids

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 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: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or Louisiana Department of Insurance at 1-800-259-5300 or ldi.la.gov.

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 1-888-331-3408.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-331-3408.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-331-3408.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-331-3408.

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** $1,500
- Specialist copay $45
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal 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	$1,500
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,470**

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

- **The plan's overall deductible** $1,500
- Specialist copay $45
- 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	$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,250**

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

- **The plan's overall deductible** $1,500
- Specialist copay $45
- 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	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$100
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a c omplaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

st 'E!: e l- 0 -f(Korea n) Af-§- 3 .A.le- 9- '2:!O-f ;r;j .Ai.l::IL.A.. ¥.si.£ Ol§-"B * £.!:::;LI C . s!j .lgil. R Qf.Ai. (S ummary of Benefits and Coverage, SBC) l 7 1A!I ¥ .si. * lc!:! £ * "5 .A1.2. .

PAUNA\VA: Kungnagsasalita ka ng Tagalog (Tagalog), may makukuha kang mgalibreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

BHHMAHHE: 6ecnnanu. re YCJIYI'H nepes o;1a;1ocrymu,r AJlJI mo;1eli, "!el!po,D;Holi ll3hlK JmJJJleTCJI pyccKoM (R ussia n). Ilo3BOHHTe no 6ec nJiaTHoMy HOMep y TeJieq>oHa, yxa3aHHOMYB,llaHHOM«Ofoope m,ro TH no 1<ph!n u1» (Summary of Benefits and Coverage, SBC).

I, y l j.J I J;. 1.,i<::.J.w l ._.;4-,JI<..11J+il ?'.J! JL,..:i I -J . u.."',µ4-,JI <..;.,.Jll .oc.W Id.....,;, J.,> **(Arabic)** I u:6 1:):"-.1,W .1:.,,, (Summary of Benefits and Covera,ge SBC)

ATANSYON: Si wpale **Kreyol ayisyen (Haitian Creole),** ou kapab benefisye sevis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteks yon sa a (Summary of Benefits and Coverage,SBC).

ATTENTION : Si vous parlez **franc;ais (Fre nch),** des services d'aide linguistique vous sont proposes gratuitement. Veuillez appeler le numero sans frais figurant dans ce Sommaire desprestations et dela couverture (Summary of Benefits and Coverage,SBC).

1 J'\,VAGA: Jezeli m6wisz po **polsku (Polish),** udost pnilismy darmowe uslugi tlumacza. Prosimy zadzwonicpod bezplatny numer podany w niniejszym Zesta wieniu swiadczen i refundacji (Summary of Benefits and Coverage, SBC).

ATEN<;:AO: Se voce fala portugues (Portuguese), contate o servic;o de assist encia deidiomas gratuito. Ligue para o numero gratuito listado neste Resumo de Beneficios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE:in caso la lingua parlata sia **l'italiano (Italian),** sono disponibili servizi di assistenza linguistica gratuiti. Chiamate ii numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage,SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfugung. Bitterufen Sie die in dieser Zusammenfassung der Leistungen und Kostenubernahmen (Summary of Benefits and Coverage,SBC) angegebene gebuhrenfreie Rufnummer an.

7.± :t : **B:+ (Japanese)** j;s tl,,'5 -g., 1ffi* O) i!3'lti'if-l::'.A::'.'f1Jffiv't::t::: t T.
7-[!: r{* it:s'J:triit{;j'O)ffll J (Summary of Benefits and Coverage, SBC) .:ic! h'"rv' Q7 ¼
- .{ "l"JJ.,. -='"[t:s' i;s \ t::: **It'.**

t.fo:,_>l) y l j.o.._____i)JI.JO, .,.,fa J1_;L; .:.,il:i,_;W \.; w.l _,,;,t.;'-"' W _; I _;, J1_;L; _;_,lo'-,/ .,..l.;j .,l.,1 d...,;. u..,\ **(Farsi)** irv\j WJ;jp l: ;;
.:,;.»-; <Y'W (Summary of Benefits and Covera,ge SBC)

t-<llo'f t: <TT?; 3{Jq **(Hindi)** . :HJ1!f1 f1$1<lc'11 . f.t: 11><1> 3q<>1,st:f l ffi31 .3ITT cf>d :,j (Summary of Benefits and Coverage,SBC) {1l'fflf c'H f1-q isl GIB cf>ZI

CEEBTOOM: Yog koj hais Lus **Hmoob (Hmong),** muaj kev pab txhais!us pub dawb rau koj. Tho v hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

frn.mUH'l!JiM: IUNS!;!l'iSW1WmMi 1 **(Kh mer)** lflJlla wmnn1Chwl'll'ieil'liMiil:flSI\ITTUljl'i'1 QlfiJ IS'llnJ81'1l'iml!)lMitlnJl:fl2l'ifils1Qll lf\J13Uf\J1\1UH!JLUllU1clS Sllmlhu61ll (Summary of Benefits and Coverage, SBC)12:'1

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang tilengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awaganti awan bayad na nu t.awagan nga numero nga nakalist.a iti uneg na daytoynga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage,SBC).

Dfi BAA'AKONINIZIN: **Dine (Navajo)** bizaad bee yanilti'go, saad bee aka'anida'awo'igii,t'aa jiik'eh, bee na'ah66t'i'. Taa shqqdi Naaltsoos Bee 'Aa'ahayani d66 Bee 'Ak'e'asti' Bee Baa Hane'i (Summary of Benefits and Coverage,SBC) biyi' t'aa jiik'ehgo beesh bee hane'i bika'igii beehodiilnih.

OGO\.V Haddii aad ku hadasho **Soomaali (Somali),** adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage,SBC).