UnitedHealthcare
UnitedHealthcare Life Insurance Company

Silver Copay Select 1

Coverage Period: Beginning on or after 01/01/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | **Plan Type:** PPO

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.uhone.com or by calling 1-800-657-8205.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$5,000** person for network **/ $10,000** person for non-network. Does not apply to copays, prescription drugs and services listed below as "No charge".	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 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?	Yes, **$250** for each emergency room visit for illness if not admitted. **$750** combined for outpatient prescription drugs Tiers 3 & 4. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes, **$6,100** person **/ $12,200** family for network. No, for non-network.	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?	Penalties for services from non-network providers, penalties for failure to obtain prior authorization, premiums, balance-billed charges, and health care this plan does not cover.	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 chart starting on page 2 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. See www.uhone.com **or call 1-800-657-8205** for a list of network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-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?	Yes, except for obstetrical or gynecological treatment, you must obtain an electronic or oral referral to see a network specialist.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-657-8205 or visit us at www.uhone.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-657-8205 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-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**, **copayments** and **coinsurance** amounts.

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	$20 copayment/ visit	25% penalty, then non-network deductible, then 20% coinsurance	Copayment applies to history and exam only. Other covered services including surgery subject to deductible and coinsurance.
	Specialist visit	$40 copayment/ visit	25% penalty, then non-network deductible, then 20% coinsurance	Copayment applies to history and exam only. Other covered services including surgery subject to deductible and coinsurance.
	Other practitioner office visit	$40 copayment/ visit	25% penalty, then non-network deductible, then 20% coinsurance	Copayment applies to history and exam only. Other covered services including surgery subject to deductible and coinsurance. Spinal manipulation is limited to 20 visits per person per calendar year.
	Preventive care/screening/ immunization	No charge	25% penalty, then non-network deductible, then 20% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	You must obtain prior authorization for non-network or benefits are reduced by 20%.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	You must obtain prior authorization for non-network or benefits are reduced by 20%.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.uhclic.welcometouhc.com	Outpatient Tier 1 drugs	$10 copayment/ prescription or refill	$10 copayment/ prescription or refill	Limited to a 34-day supply per prescription or refill. Some contraceptives are payable under preventive care without the copayment. If a name brand drug is purchased and a generic drug is available, you pay the difference. Prior authorization may be required for some drugs. Outpatient prescription drug deductible applies to Tiers 3 & 4. Generics may reside in any Tier.
	Outpatient Tier 2 drugs	$40 copayment/ prescription or refill	$40 copayment/ prescription or refill	
	Outpatient Tier 3 drugs	20% coinsurance with $150 copay minimum	20% coinsurance with $150 copay minimum	
	Outpatient Tier 4 drugs	30% coinsurance with $300 copay minimum	30% coinsurance with $300 copay minimum	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	You must obtain prior authorization for non-network or benefits are reduced by 20%.
	Physician/surgeon fees	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	Assistant surgeon's fee is limited to 20% of the eligible expense for the surgical procedure (if not a doctor limited to 14%).
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible	20% coinsurance after deductible	A $250 emergency room deductible is applied for an illness if not directly admitted to the hospital.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Air ambulance outside the U.S. not covered.
	Urgent care	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	You must obtain prior authorization for non-network or benefits are reduced by 20%.
	Physician/surgeon fee	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	Assistant surgeon's fee is limited to 20% of the eligible expense for the surgical procedure (if not a doctor limited to 14%).

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copayment/ visit	25% penalty, then non-network deductible, then 20% coinsurance	Copayment for outpatient applies to history and exam only. Other covered services subject to deductible and coinsurance. You must obtain prior authorization for certain non-network services or benefits are reduced by 20%.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	
	Substance use disorder outpatient services	$20 copayment/ visit	25% penalty, then non-network deductible, then 20% coinsurance	
	Substance use disorder inpatient services	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	
If you are pregnant	Prenatal and postnatal care	No charge	25% penalty, then non-network deductible, then 20% coinsurance	Complications of pregnancy are covered. Prenatal office visits, certain prenatal blood tests, and prenatal tobacco cessation counseling may be covered under preventive care. Certain postnatal services are subject to deductible and coinsurance. You must obtain prior authorization for non-network inpatient or benefits are reduced by 20%.
	Delivery and all inpatient services	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	Limited to a maximum of 60 visits per covered person per calendar year for the care and treatment of a homebound person within 30 days of an inpatient hospital stay. You must obtain prior authorization for non-network or benefits are reduced by 20%.
	Rehabilitation services	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	Inpatient for rehabilitation and extended care facility are limited to combined maximum of 120 days per person, per calendar year. You must obtain prior authorization for non-network or benefits are reduced by 20%.
	Habilitative services	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	Habilitation services do not include: Services that are solely educational in nature; treatment of mental disorders, other than congenital, genetic, or early acquired disorders; custodial or respite care, day care, therapeutic recreation, vocational training, or residential treatment.

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
	Skilled nursing care	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	Inpatient for rehabilitation and extended care facility are limited to combined maximum of 120 days per person, per calendar year. You must obtain prior authorization for non-network or benefits are reduced by 20%.
	Durable medical equipment	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	You must obtain prior authorization for non-network equipment exceeding $1,000 in cost or benefits are reduced by 20%.
	Hospice service	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	Limited to a prognosis of 12 months or less to live. You must obtain prior authorization for a non-network inpatient stay at a hospice or benefits are reduced by 20%.
If your child needs dental or eye care	Eye exam	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	Limited to one exam per calendar year.
	Glasses	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Dental check-up	20% coinsurance after deductible	25% penalty, then non-network deductible, then 20% coinsurance	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

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
- Air ambulance outside the U.S.
- Bariatric surgery
- Cosmetic surgery (except when necessary due to a covered illness or injury)
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)**

- Chiropractic care – limited to 20 visits
- Infertility treatment- limited to basic diagnostic services

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (800) 657-8205. You may also contact your state insurance department at (877) 881-6388.

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 contact Pennsylvania Department of Insurance at (877) 881-6388.

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**.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (800) 657-8205.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 657-8205.
Chinese (中文): **如果需要中文的帮助**, 请拨打这个号码 (800) 657-8205.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'(800) 657-8205.

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** $1,120
- **Patient pays** $6,420

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	$5,900
Copays	$20
Coinsurance	$300
Limits or exclusions	$200
Total	**$6,420**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,160
- **Patient pays** $1,240

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
Copays	$900
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,240**

Questions and answers about the 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 by 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.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.