UnitedHealthcare®

IHF Choice Plan

Coverage Period: 01/01/2016– 12/31/2016

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 1-866-405-0797.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,500** Individual / **$3,000** Family Per Calendar year. Does not apply to prescription drugs, and services listed below as "No Charge".	With the exception of certain copay services, 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?	**Medical:** Network: **$5,600** Individual / **$11,200** Family **Prescription Drugs:** **$1,000** Individual / **$2,000 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 applies to each calendar year as the maximum you pay, including deductibles, coinsurance and copays for covered 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.	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**. Use of non-network **providers** are not covered by this plan. For a list of network **providers**, see **www.myuhc.com** or call **1-866-405-0797** 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 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**.)
- 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	Up to 4 Visits: $20 Copay 5+ Visits: Subject to deductible and 30% co-ins.	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. All services with a copay are combined for the purposes of the 4 visit provision grouped for primary care and specialist type care.
	Specialist visit	Up to 4 Visits: $35 Copay 5+ Visits: Subject to deductible and 30% co-ins	Not Covered	
	Other practitioner office visit	Up to 4 Visits: $35 Copay 5+ Visits: Subject to deductible and 30% co-ins	Not Covered	Treated as a Speciality Visit. Limited to 45 visits of Manipulative (Spinal) services per Calendar year.
	Preventive care / screening / immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	30% co-ins, after ded.	Not Covered	None
	Imaging (CT / PET scans, MRIs)	30% co-ins, after ded.	Not Covered	None
If you need drugs to treat your illness or condition	Tier 1 – Generic	Retail: $10 copay Mail-Order: $20 copay	Not Covered	The 2015 prescription plan includes an out-of-pocket maximum of $1,000 per individual and $2,000 per family per calendar year, providing a limit on the total amount you pay in copays in the year.
	Tier 2 – Brand Formulary	Retail: $30 copay Mail-Order: $60 copay	Not Covered	

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.savrx.com**	Tier 3 – Brand Non-Formulary	Retail: $60 copay Mail-Order: $120 copay Those with generic equivalent, member pays the difference in cost between Brand and Generic plus the applicable copay.	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 Participants can utilize any retail pharmacy as a walk in mail order to receive mail order benefits Participants must submit receipts for reimbursement for out-network claims. No Walmart or Sams club will be reimbursed
	Tier 4 – Specialty	25% Copay	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-ins, after ded.	Not Covered	None
	Physician / surgeon fees	30% co-ins, after ded.	Not Covered	None
If you need immediate medical attention	Emergency room services	30% co-ins, after ded.	Not Covered	Copay is waived if you are admitted for Inpatient stay directly from the Emergency Room.
	Emergency medical transportation	30% co-ins, after ded.	Not Covered	None
	Urgent care	Up to 4 Visits: $50 Copay 5+ Visits: Subject to deductible and 30% co-ins	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-ins, after ded.	Not Covered	Pre-Notification is required or $250 penalty applies for not notifying.
	Physician / surgeon fees	30% co-ins, after ded..	Not Covered	None
If you need help recovering or have other special health needs	Mental / Behavioral health outpatient services	Up to 4 Visits: $35 Copay 5+ Visits: Subject to deductible and 30% co-ins	Not Covered	Benefits covered like any other Specialist visit with no day limitation.
	Mental / Behavioral health inpatient services	30% co-ins, after ded.	Not Covered	Benefits for inpatient/intermediate Services covered as any other

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
				inpatient/intermediate Services. Pre-Notification is required or $250 penalty applies for not notifying.
	Substance use disorder outpatient services	Up to 4 Visits: $35 Copay 5+ Visits: Subject to deductible and 30% co-ins	Not Covered	Benefits covered like any other Specialist visit with no day limitation.
	Substance use disorder inpatient services	30% co-ins, after ded.	Not Covered	Benefits for inpatient/intermediate Services covered as any other inpatient/intermediate Services. Pre-Notification is required or $250 penalty applies for not notifying.
If you become pregnant	Prenatal and postnatal care	Up to 4 Visits: $35 Copay 5+ Visits: Subject to deductible and 30% co-ins	Not Covered	Additional copays, deductibles, or co-ins may apply. Network routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	30% co-ins, after ded.	Not Covered	Inpatient Pre-Notification may apply or $250 penalty applies for not notifying.
If you have a recovery or other special health needs	Home health care	30% co-ins, after ded.	Not Covered	Limited to 40 visits per Calendar year (1 visit equals up to 4 hours of skilled care services). Pre-Notification is required or $250 penalty applies for not notifying.
	Rehabilitation services	Up to 4 Visits: $35 Copay 5+ Visits: Subject to deductible and 30% co-ins	Not Covered	Limited to 45 visits per therapy, per Calendar year.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation services.
	Skilled nursing care	30% co-ins, after ded.	Not Covered	Skilled nursing care benefits are limited to 120 days per Calendar year. Inpatient Rehabilitation services are limited to 30 days per Calendar year. Pre-Notification is required or $250 penalty applies for not notifying.

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	30% co-ins, after ded.	Not Covered	Pre-Notification is required for DME over $1,000 or $250 penalty applies for not notifying.
	Hospice service	30% co-ins, after ded.	Not Covered	Network and Non-Network Benefits are unlimited during the entire period of time a Covered Person is covered under the Plan. Inpatient Pre-Notification is required or $250 penalty applies for not notifying.
If your child needs dental or eye care	Eye exam	Member pays the applicable office visit charge	Not Covered	Covers charges for testing & treatment due to illness or injury only.
	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	• Habilitation services • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • 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- may be covered with limitations • Bariatric surgery- may be covered with limitations	• Chiropractic care - may be covered with limitations • Hearing aids - may be covered with limitations	• Private-duty nursing- may be covered with limitations • Routine eye care (Adult) - may be covered with limitations

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 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 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.

Language Access Services:

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** $4,550
- ☐ **Patient Pays** $2,990

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	$2,400
Co-pays	$110
Co-insurance	$480
Limits or exclusions	$0
Total	**$2,990**

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

- ☐ **Amount owed to providers:** $5,400
- ☐ **Plan Pays** $2,652
- ☐ **Patient Pays** $2,588

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	$1,500
Co-pays	$860
Co-insurance	$128
Limits or exclusions	$0
Total	**$2,588**

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 1-866-405-0797 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. **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.