UnitedHealthcare

ASO HDHP with HSA Plan

Coverage Period: 01/01/2013 – 01/01/2013

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 1 888-322-2646

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$2,000** Individual */ **$4,000** Family Non-Network: **$2,000** Individual / **$4,000** Family Doesn't apply to services listed below as "No Charge." Per calendar year. *Doesn't apply if policy covers 2+ people.	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?	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: **$3,000** Individual */ **$6,000** Family Non-Network: **$5,000** Individual / **$10,000** Family *Doesn't apply if policy covers 2+ people.	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.	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 1 888-322-2646 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, $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	10% co-ins	30% co-ins	None
	Specialist visit	10% co-ins	30% co-ins	None
	Other practitioner office visit	10% co-ins per visit of Manipulative (Chiropractic) services	30% co-ins per visit of Manipulative (Chiropractic) services	Limited to 20 visits of Manipulative (Chiropractic) services per calendar year. Pre-Notification is required non-network.
	Preventive care / screening / immunization	No Charge	30% co-ins	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	30% co-ins	None
	Imaging (CT / PET scans, MRIs)	10% co-ins	30% co-ins	None
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest-Cost Option	Retail: $10 copay Mail-Order: $20 copay	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, 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.
More information about prescription drug coverage is available at **www.myuhc.com**	Tier 2 – Your Midrange-Cost Option	Retail: $25 copay Mail-Order: $50 copay	Retail: Not Covered Mail-Order: 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
	Tier 3 – Your Highest-Cost Option	Retail: $50 copay Mail-Order: $100 copay	Retail: Not Covered Mail-Order: Not 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 1 Contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 4 – Additional High-Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins	30% co-ins	Pre-Notification is required non-network.
	Physician / surgeon fees	10% co-ins	30% co-ins	None
If you need immediate medical attention	Emergency room services	10% co-ins	10% co-ins	None
	Emergency medical transportation	10% co-ins	10% co-ins	None
	Urgent care	10% co-ins	30% co-ins	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins	30% co-ins	Pre-Notification is required non-network.
	Physician / surgeon fees	10% co-ins	30% co-ins	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	10% co-ins	30% co-ins	None
	Mental / Behavioral health inpatient services	10% co-ins	30% co-ins	Pre-Notification is required non-network.
	Substance use disorder outpatient services	10% co-ins	30% co-ins	None
	Substance use disorder inpatient services	10% co-ins	30% co-ins	Pre-Notification is required non-network.
If you become pregnant	Prenatal and postnatal care	10% co-ins	30% co-ins	Routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	10% co-ins	30% co-ins	Additional copays, deductible, co-insurance or Notification may apply.
If you have a recovery or	Home health care	10% co-ins	30% co-ins	Limited to 90 days per calendar year.

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
other special health needs				Pre-Notification is required non-network.
	Rehabilitation services	10% co-ins	30% co-ins	Depending on the type of therapy, there is a limit of 20-90 visits per calendar year.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation services.
	Skilled nursing care	10% co-ins	30% co-ins	Limited to 30 days per calendar year. Pre-Notification is required non-network.
	Durable medical equipment	10% co-ins	30% co-ins	$5,000 maximum per calendar year if the benefit/device is determined to be non-essential. Pre-Notification is required for DME over $1,000. Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice service	10% co-ins	30% co-ins	Inpatient Pre-Notification is required non-network.
If your child needs dental or eye care	Eye exam	No 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	• Glasses • Habilitation Services • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Routine eye 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.)		
• Bariatric Surgery may be covered with limitations	• Hearing Aids may be covered with limitations	• Infertility Treatment 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 (212) 229-5671 x4942. 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.

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

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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** $ 5,020
- ☐ **Patient Pays** $ 2,520

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	$2,000
Co-pays	$20
Co-insurance	$300
Limits or exclusions	$200
Total	**$2,520**

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

- ☐ **Amount owed to providers:** $5,400
- ☐ **Plan Pays** $ 3,520
- ☐ **Patient Pays** $ 1,880

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	$1,100
Co-pays	$700
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,880**

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 1 888-322-2646 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.