




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, contact United Healthcare at [www.myuhc.com](http://www.myuhc.com) or by calling 866-844-4864. 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 <https://www.healthcare.gov/sbc-glossary/>

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	Network: <b>0</b> Individual / <b>\$0</b> Family Non-Network: <b>\$1,000</b> Individual / <b>\$3,000</b> Family. Does not apply to copays, Per calendar.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> . <a href="#">Deductible</a> starts over each year starting January 1st
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No. There are no other <a href="#">deductible</a>	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
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$8,550 individual / \$17,100 family; for <a href="#">out-of-network providers</a> \$4,000 individual / \$8,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 866-844-4864 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No, You don't need a referral to see a specialist	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services.

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /office visit Tier One \$25 <a href="#">copay</a> /office visit Non Tier One. <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> /office visit Tier One \$30 <a href="#">copay</a> /office visit Non Tier One. \$50 <a href="#">copay</a> /office visit Orthopedic Non Tier One Providers. <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is NOT required. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. <b>Chiropractic services covered in-network only.</b>
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$25 <a href="#">copay</a> /test	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	When services are performed at a Hospital the copay is \$40 per visit.
	Imaging (CT/PET scans, MRIs)	No Charge	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myuhc.com">www.myuhc.com</a>	Tier 1 or for most Generic Drugs. Your Lowest-Cost Option	\$5 for each 30 day supply at a Retail Pharmacy \$10 Mail Service	\$5 for each 30 day supply at a Retail Pharmacy Mail-Order: Not Covered	Certain medications require prior authorization for coverage, including certain specialty drugs. 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. Specialty drugs limited to a 30 day supply.
	Tier 2, Preferred Drugs. Your Midrange-Cost Option	\$25 for each 30 day supply at a Retail Pharmacy \$37.50 Mail Service	\$25 for each 30 day supply at a Retail Pharmacy Mail-Order: Not Covered	
	Tier 3 or Non-preferred Drugs. Your Highest-Cost Option	\$50 for each 30 day supply at a Retail Pharmacy \$75 Mail Service	\$50 for each 30 day supply at a Retail Pharmacy Mail-Order: Not	

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)	
			Covered	
	Tier 4 Additional High-Cost Option	\$75 at a Retail Pharmacy \$112.50 Mail Service	\$75 at a Retail Pharmacy Mail-Order: Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$60 <a href="#">copay</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. Medical necessity is required
	Physician/surgeon fees	No Charge	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Medical necessity is required
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$70 <a href="#">copay</a> per visit	\$70 <a href="#">copay</a> per visit	Copayment is waived if admitted.
	<a href="#">Emergency medical transportation</a>	No Charge for the first \$50, then 20% co-ins for the balance	No Charge for the first \$50, then 20% co-ins for the balance	
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 per confinement	\$100 per confinement after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required non-network. Medical necessary is required.
	Physician/surgeon fees	No Charge	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Provider fee in addition to facility fee applies only if the provider bills separately from the facility.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copay</a> /office visit Tier One \$25 <a href="#">copay</a> /office visit Non Tier One <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for some mental health and substance abuse services.
	Inpatient services	\$100 per confinement	\$100 per confinement after <a href="#">deductible</a>	
If you are pregnant	Office visits	\$25 <a href="#">copay</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Routine pre-natal care
	Childbirth/delivery professional services	\$20 <a href="#">copay</a> /office visit Tier One \$25 <a href="#">copay</a> /office visit Non Tier One <a href="#">deductible</a> does not apply	10% <a href="#">coinsurance</a> ; 20% <a href="#">coinsurance</a> for provider	

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	\$100 per confinement	services not billed by hospital \$100 per confinement after <a href="#">deductible</a>	is covered at No Charge
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	50% <a href="#">coinsurance</a>	Limited to 4 hours per day, <a href="#">Preauthorization</a> is required; non-network benefits apply if not precertified. No non-network coverage for the first 48 hours of home nursing. Custodial Care is not covered.
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copay</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Outpatient hospital rehabilitation services covered when medically necessary following a related hospitalization or surgery.
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	
	<a href="#">Skilled nursing care</a>	No Charge	No Charge	In-Network coverage only, limited to 4 hours per day. Custodial care not covered
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Pre-Notification is required for DME over \$1,000 when you use a Non-Network provider. Covers 1 per type of DME (including repair/replacement) every 3 years.
	<a href="#">Hospice services</a>	No Charge	No Charge	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not covered	None
	Children's glasses	Not Covered	Not covered	None
	Children's dental check-up	Not Covered	Not covered	None

#### 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](#).)**

- |                             |  |  |
|-----------------------------|--|--|
| • Cosmetic Surgery          | • Long Term Care                                     | • Routine eye care (Adult & Child)             |
| • Dental Care (Adult/Child) | • Non-emergency care when traveling outside the U.S. | • Routine Foot Care                            |
| • Custodial care            | • Private Duty Nursing                               | • Services that are not medically necessary    |
|                             |  | • Weight loss programs, other than Real Appeal |

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- |   |  |  |
|---|--|--|
| • Bariatric Surgery                                       | • Chiropractic Care- Covered in-network only | • Prescription Drugs   |
| • Acupuncture (if prescribed for rehabilitation purposes) | • Dialysis covered in-network only           | • Hearing Aids- limited to \$2,500 per ear every 36 months for adults/ two years for children under 12 |

**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 under the plan. Other limitations on your rights to continue coverage may also apply. 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](http://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 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: Contract District's Employee Benefit Supervisor 631-874-1995.

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet 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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

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*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1000
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing In-Network	
Deductibles	\$0
Copayments	\$120
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$120.00</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1000
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing In-Network	
Deductibles*	\$0
Copayments	\$60
Prescription Drugs	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$360.00</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1000
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing In-Network	
Deductibles*	\$0
Copayments ER / Therapy	\$160
Durable medical equipment ( <i>crutches</i> )	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$160.00</b>