

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 uhc.com/individual-and-family/medical-policy or by calling 1-877-512-9939.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	Network: \$1,200 individual / \$2,400 family Out-of-Network: \$2,400 individual / \$4,800 family Per calendar year. Does not apply to services listed below with copays or "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 <u>deductibles</u> for specific services?	Yes, Prescription drugs for tiers 3 and 4- \$500 per person. There are no other deductibles .	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. Network: \$5,200 individual / \$10,400 family Out-of-Network: Unlimited	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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges and health care this plan doesn't cover, and penalties for failure to obtain pre-authorization 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 chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of network providers , see uhc.com/find-a-physician/xazcompass or call 1-877-512-9939.	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 <u>specialist</u> ?	No.	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 on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-877-512-9939 or visit us at uhc.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 cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

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- **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 with a Referral	Your Cost If You Use a Network Provider without a Referral	Your Cost If You Use a Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay per visit	\$30 copay per visit	50% coinsurance after deductible	Primary care provider (PCP) must be assigned. No referral required for OB/GYN. Virtual visits (Telehealth) - \$10 copay per visit by a designated virtual network provider. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Specialist visit	\$60 copay per visit	\$100 copay per visit	50% coinsurance after deductible	We only accept electronic referrals from the assigned PCP. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Other practitioner office visit	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Unlimited visits for manipulative (chiropractic) services per year. Pre-authorization required out-of-network or benefit reduces to 50% of allowed.
	Preventive care / screening / immunization	No Charge	No Charge	50% coinsurance after deductible	Includes preventive health services.
If you have a test	Diagnostic test (x-ray, blood work)	Freestanding: 30% coinsurance after deductible	Freestanding: 30% coinsurance after deductible	50% coinsurance after deductible	Hospital: 50% coinsurance after deductible Pre-authorization required out-of-network for Sleep Studies or benefit reduces to 50% of

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					allowed
	Imaging (CT / PET scans, MRIs)	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Hospital: \$400 imaging per occurrence. The \$400 applies before the annual deductible. Pre-authorization required out-of-network or benefit reduces to 50% of allowed
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <u>uhc.com/rxfind</u>	Tier 1 – Your Lowest-Cost Option	Retail: \$10 copay	Retail: \$10 copay	Retail: \$10 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Not Covered. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-authorization requirement or may result in a higher cost. If you use an out-of-network pharmacy, you may be responsible for any amount over the coinsurance amount. Tier 1 Contraceptives covered at No Charge. You may be required to use a lower-cost drug(s). Not all drugs are covered. Pharmacy Deductible does not apply to Tier 1 & 2.
	Tier 2 – Your Midrange-Cost Option	Retail: \$50 copay	Retail: \$50 copay	Retail: \$50 copay	
	Tier 3 – Your Highest-Cost Option	Retail: 20% coinsurance after deductible with a \$85 copay min	Retail: 20% coinsurance after deductible with a \$85 copay min	Retail: 20% coinsurance after deductible with a \$85 copay min	
	Tier 4 – Additional High-Cost Options	Retail: 30% coinsurance after deductible with a \$250 copay min	Retail: 30% coinsurance after deductible with a \$250 copay min	Retail: 30% coinsurance after deductible with a \$250 copay min	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Freestanding: 30% coinsurance after deductible	Freestanding: 50% coinsurance after deductible	Freestanding: 50% coinsurance after deductible	Hospital: \$400 outpatient surgery per occurrence. The \$400 applies before the annual deductible. For certain services, pre-authorization required out-of-network or benefit reduces to 50% of allowed.
	Physician / surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	_____none_____
If you need immediate	Emergency room services	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	\$500 emergency room per occurrence. The \$500 applies before the annual deductible.

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medical attention	Emergency medical transportation	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	_____none_____
	Urgent care	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization required out-of-network or benefit reduces to 50% of allowed
	Physician / surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	\$30 copay per visit	\$30 copay per visit	50% coinsurance after deductible	Partial hospitalization/intensive outpatient treatment: 30% coinsurance after deductible For certain services, pre-authorization required out-of-network or benefit reduces to 50% of allowed.
	Mental / Behavioral health inpatient services	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization required out-of-network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	\$30 copay per visit	\$30 copay per visit	50% coinsurance after deductible	Partial hospitalization/intensive outpatient treatment: 30% coinsurance after deductible. For certain services, pre-authorization required out-of-network or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization required out-of-network or benefit reduces to 50% of allowed
If you are pregnant	Prenatal and postnatal care	No Charge	No Charge	50% coinsurance after deductible	Additional copays, deductibles, or coinsurance may apply.
	Delivery and all inpatient services	30% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	Inpatient authorization may apply.
If you need help	Home health care	30% coinsurance	30% coinsurance	50% coinsurance	Limited to 42 visits per calendar year. Pre-

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recovering or have other special health needs		after deductible	after deductible	after deductible	authorization required out-of-network or benefit reduces to 50% of allowed
	Rehabilitation services	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Any combination of outpatient rehabilitation services is limited to 60 visits per calendar year. Pre-authorization required for physical, speech, and occupational therapy out-of-network or benefit reduces to 50% of allowed
	Habilitative services	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Limits per calendar year: physical, speech, occupational – 60 combined visits. For certain services, pre-authorization required out-of-network or benefit reduces to 50% of allowed
	Skilled nursing care	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 90 days per calendar year. (combined with Inpatient Rehabilitation) Pre-authorization required out-of-network or benefit reduces to 50% of allowed
	Durable medical equipment	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization required out-of-network for DME over \$1000 or benefit reduces to 50% of allowed.
	Hospice service	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Inpatient pre-authorization required out-of-network or benefit reduces to 50% of allowed
If your child needs dental or eye care	Eye exam	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	1 exam every 12 months.
	Glasses	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	1 pair every 12 months. Cost may increase depending on the frames.
	Dental check-up	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Cleanings covered 2 times per 12 months. Limitations may apply.

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.)

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<ul style="list-style-type: none"> • Abortion (Except for rape, incest, life at risk) • Acupuncture 	<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Weight loss programs
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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.)

<ul style="list-style-type: none"> • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care • Hearing aids 	<ul style="list-style-type: none"> • Private-duty nursing – Inpatient 	<ul style="list-style-type: none"> • Routine foot care
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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 1-800-318-5311. You may also contact your state insurance department at Arizona Department of Insurance at 1-602-364-2499 in Phoenix or 1-800-325-2548 in AZ but outside Phoenix or <http://www.id.state.az.us/>.

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 Arizona Department of Insurance at 1-602-364-2499 in Phoenix or 1-800-325-2548 in AZ but outside Phoenix or <http://www.id.state.az.us/>.

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.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-512-9939.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-512-9939.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-512-9939.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-512-9939.

-----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 \$4,620
- Patient pays \$2,920

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	\$1,200
Copays	\$20
Coinsurance	\$1,500
Limits or exclusions	\$200
Total	\$2,920

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

- Amount owed to providers: \$5,400
- Plan pays \$3,560
- Patient pays \$1,840

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	\$1,500
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$1,840

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 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.

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.

Questions: Call 1-877-512-9939 or visit us at uhc.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 cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.