TEXAS HEALTH CARE NEWSLETTER

November 13, 2015
(Volume X1I, Edition 23)

Texas Health Care was founded to allow doctors to be doctors.
Our priority is simple: provide quality care to our patients.

For your convenience, the Payroll department will be available the day after Thanksgiving from 9 – 11am to answer any questions you may have concerning your 11/27/2015 payroll check.

The attached two United Healthcare 2016 Summary of Benefits and Coverages (SBC's) were electronically mailed to our THC employees and physicians 11/01/2015, distributed during our enrollment meetings and are attached to the newsletter for your convenience.

2016 SBC Base Plan and 2016 SBC Buy Down Plan

You may also download copies from the Woodard Insurance website https://woodardinsurance.box.com/thc password **"THC" (case sensitive).**" Copies are also available on the website and intranet MS Outlook Employee Public Files.
If you are unable to view/print documents, please contact Cindy Wooley for printed document copy.

Texas Health Care, PLLC - Open Enrollment

What do I do?

Please complete and submit forms as soon as possible as you only have two more weeks!!
Send Forms before the Thanksgiving Holiday to meet your due date of Tuesday, December 1st.

If you ARE NOT making changes
YOU **MUST** submit
1. Section 125 Cafeteria Plan Salary Reduction Agreement (SRA) form AND
2. 2016 Nicotine-Use Certification form

If you ARE MAKING changes YOU **MUST** submit
1. Section 125 Cafeteria Plan Salary Reduction Agreement (SRA) form AND
2. 2016 Nicotine-Use Certification form AND
3. Carrier (medical, vision, dental, STD/LTD) Enrollment/Change form(s)

IF you are enrolled in medical, dental or a vision benefit, although your current elected benefits will "roll" to the next policy year—Premiums will default to the after tax deduction for the 2016 plan year if you do not submit a 2016 Section 125 Salary Reduction Agreement by the due date of 12/01/2015.

Employees with medical coverage through United Healthcare will be responsible for nicotine surcharge for the entire 2016 plan year if the certification form is not returned OR if the employee has indicated nicotine usage and does not COMPLETE enrollment in the Quit For Life Program by 12/01/2015
SURCHARGE WILL BE DEDUCTED FOR THE ENTIRE 2016 PLAN YEAR regardless of nicotine usage.

As a reminder, IF you are enrolled in the Lincoln Voluntary Life, Short-Term and Long-Term Disability plans, your current elected benefits will "roll" to the next policy year WITHOUT any additional forms. If you wish to add Short Term OR Long Term Disability coverage, please complete the Enrollment form provided for NEW enrollment.

FORMS ARE DUE AT THE CBO NO LATER THAN 12/01/2015

Employees not attending a meeting can obtain applicable forms through Woodard's internet, our company intranet or request assistance from their PTL.
Woodard's website https://woodardinsurance.box.com/thc password **THC** *(case sensitive)*
Company Intranet: MS Outlook Public Folder – Employee Benefits – 2016 Open Enrollment
If you do not have computer access, please contact your PTL/Supervisor in order to print applicable forms.

Benefits Premiums for Plan Year 2016

DENTAL Aetna – High/Low Plans

Please review Summary Plans for coverage

Contract 846821 www.aetna.com

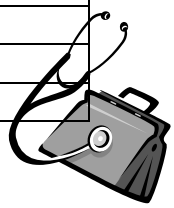
Aetna Dental (Biweekly Rates)	High Plan	Low Plan
Employee only	$ 21.48	$ 12.60
Emp + one dependent	$ 43.28	$ 27.16
Emp + 2 or more	$ 61.13	$ 36.21

MEDICAL/HEALTH - United HealthCare (Medical/Health)

Please review Summary Plans for complete breakdown on coverage for the 2016 plan year.

Contract 706935 www.myuhc.com

United Healthcare Medical (Biweekly Rates)	Base Plan	BuyDown Plan
Employee only	$ 50.00	$ 20.00
Emp + Spouse	$412.26	$291.22
Emp + Child(ren)	$346.40	$241.91
Emp + Family	$659.28	$476.15



VISION United HealthCare

Please review Summary Plans for coverage.

Contract 706935 (stand-alone vision plan) www.uhcvision.com

United Healthcare Vision (Biweekly Rates)	IF covered on THC Health Plan	If NOT Covered on THC Health Plan
Employee Only	FREE	$ 2.70
Employee + Spouse	$ 1.90	$ 4.60
Employee + Child(ren)	$ 2.13	$ 4.83
Employee + Family	$ 3.95	$ 6.65

Other Collections Recognition Program

If you collect an outstanding patient balance for another THC Physician and complete the new "Other Collections" form, you become eligible for a prize! The following employees collected for another THC Physician and competed for prizes in the month of October

Employee	Office	Employee	Office	Employee	Office
Baird, Leslie	BEKP	Hukill, Ashley	B-320	Rodriguez, Olivia	CBO-JPS
Chancellor, Sue	PT Office	McBride, Alesha	Rosenthal	Winborn, Allegra	CDLBL
Crawford Phillips, Sunny	PMB	Parks, Sherry	GW	Zamora, Michelle	B-440
Freeman, Carol "Baba"	BEKP	Pena Hernandez, Cristina	CKC	Rodriguez, Olivia	CBO-JPS
Garcia, Sendy	HVMK	Pizana, Victoria	HVMK		
Haidusek, Lauren	B-435	Richburg, Theresa	GW		
Hueso, Joan	Hulen OB	Roberts, Melissa	B-435		

October Winners:
Alesha McBride, Sherry Parks and Olivia Rodriguez

"THC recently sent you the 2014 Summary Annual Report (SAR) for the Texas Health Care PLLC Welfare Benefits Plan, affectionately known as the Wrap Plan, the Texas Health Care PLLC Cafeteria Plan, and the Texas Health Care, P.L.L.C. 401(k) Retirement Plan. If you did not receive your SARs, please call Cindy Wooley at 817-740-8406 for a copy, or you can download a copy of the 2014 SARs from the Woodard Insurance website (**https://woodardinsurance.box.com/thc**). **The password is "THC" (case sensitive).**"

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 1-866-633-2446

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,500 Individual/$3,000 Family Per Calendar Year Doesn't apply to preventive care. Copays, prescription drugs, and services listed below as "No Charge" do not apply to the deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use that are subject to the deductible. 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. Prescription Drug Deductible: $100 Individual / $300 Family	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. Network: $4,500 Individual/$9,000 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 helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, 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 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, this plan uses network providers. Except for emergency services, no benefits are paid for non-network providers. For a list of participating providers, see www.myuhc.com or call 1-866-633-2446.	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 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?	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 on page 5. See your policy or plan document for additional information about excluded services.

Questions: Call 1-866-633-2446 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 1-866-633-2446 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.

- 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 only covers services if rendered by network providers. Exceptions include emergency services as described in your policy.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Covered persons less than age 19: $0 copay per visit All other Covered Persons: Designated (Tier 1) Network: $30 copay per visit Network: $30 copay per visit Virtual visits (Telehealth): $25 copay per visit	Not Covered	Virtual visits (Telehealth) must be provided by a designated virtual network provider. If you receive certain services in an office visit setting, additional copays, deductibles, or co-ins may apply.
	Specialist visit	Designated (Tier 1) Network: $30 copay per visit Network: $60 copay per visit	Not Covered	
	Other practitioner office visit	$30 copay per visit of Manipulative (Chiropractic) services	Not Covered	Limited to 20 visits of Manipulative (Chiropractic) services per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	---------- None ----------

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible has been met	Not Covered	---------- None ----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www. myuhc.com.	Tier 1 – Your Lowest-Cost Option	Retail: $10 copay Mail Order: $25 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 1 month supply. Mail-Order: Up to a 3 month supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. **Certain drugs may have an authorization requirement or may result in a higher cost. 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 2 – Your Mid-Range Cost Option	Retail: $35 copay Mail Order: $87.50 copay	Not Covered	
	Tier 3 – Your Highest-Cost Option	Retail: $70 copay Mail Order: $175 copay	Not Covered	
	Tier 4 – Additional High-Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible has been met	Not Covered	---------- None ----------
	Physician/surgeon fees	30% coinsurance after deductible has been met	Not Covered	---------- None ----------
If you need immediate medical attention	Emergency room services	$300 copay per visit.	Same as Network	Copay is waived if you are admitted for Inpatient stay directly from the Emergency Room. **Notification is required if confined in a non-Network Hospital or benefit reduces to 50%.
	Emergency medical transportation	30% coinsurance after deductible has been met	Same as Network	---------- None ----------

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Urgent care	$75 copay per visit.	Not Covered	---------- None ----------
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible has been met	Not Covered	---------- None ----------
	Physician/surgeon fee	30% coinsurance after deductible has been met	Not Covered	---------- None ----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay per visit	Not Covered	---------- None ----------
	Mental/Behavioral health inpatient services	30% coinsurance after deductible has been met	Not Covered	---------- None ----------
	Substance use disorder outpatient services	$30 copay per visit	Not Covered	---------- None ----------
	Substance use disorder inpatient services	30% coinsurance after deductible has been met	Not Covered	---------- None ----------
If you are pregnant	Prenatal and postnatal care	$30 copay, initial visit	Not Covered	Network routine pre-natal care is covered at No Charge after initial office visit.
	Delivery and all inpatient services	30% coinsurance after deductible has been met	Not Covered	---------- None ----------
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible has been met	Not Covered	Limited to 60 visits per year.
	Rehabilitation services	$30 copay per visit	Not Covered	Depending on the type of therapy, there is a limit of 20-36 visits per year.
	Habilitation services	$30 copay per visit.	Not Covered	Limited to 20 visits per year.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Skilled nursing care	30% coinsurance after deductible has been met	Not Covered	Limited to 60 visits per year.
	Durable medical equipment	30% coinsurance after deductible has been met	Not Covered	Prior Authorization is required for Durable Medical Equipment in excess of $1,000. Covers 1 per type of DME (including repair/ replacement) every 3 years.
	Hospice service	30% coinsurance after deductible has been met	Not Covered	---------- None ----------
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

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 (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- 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– may be covered with limitations
- Hearing aids– 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 the phone number on the back of your ID card. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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.

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:

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 ID card.

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 $4,500
- Patient pays $3,040

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	$1,500
Copays	$40
Coinsurance	$1,300
Limits or exclusions	$200
Total	$3,040

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
Copays	$700
Coinsurance	$0
Limits or exclusions	$80
Total	$1,880

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.

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 1-866-633-2446.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $3,000 Individual/$6,000 Family Non-Network: $6,000 Individual/$12,000 Family Per Calendar Year Doesn't apply to preventive care. Non-network coinsurance and copayments don't count toward deductible.	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. If more than one person in a family is covered, the individual deductible does not apply. No one in the family is eligible for benefits until the family deductible is met.
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Network: $5,000 Individual/ $6,850 Family Non-Network: $10,000 Individual / $20,000 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 helps you plan for health care expenses. If more than one person in a family is covered, the individual out-of-pocket limit does not apply.
What is not included in the out–of–pocket limit?	Premiums, 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 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, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of participating providers, see www.myuhc.com or call 1-866-633-2446.	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 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?	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 on page 5. See your policy or plan document for additional information about excluded services.

Questions: Call 1-866-633-2446 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 1-866-633-2446 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.

- 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 participating providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	Includes virtual visits (Telehealth) if provided by a designated virtual network provider.
	Specialist visit	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	
	Other practitioner office visit	20% coinsurance of Manipulative (Chiropractic) services after deductible is met	40% coinsurance of Manipulative (Chiropractic) services after deductible is met	Limited to 20 visits of Manipulative (Chiropractic) services per calendar year.
	Preventive care/screening/ immunization	No Charge	40% coinsurance	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	---------- None ----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	---------- None ----------

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myuhc.com.	Tier 1 – Your Lowest-Cost Option	Retail: $10 copay Mail Order: $25 copay	Retail: $10 copay Mail Order: Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 1 month supply. Mail-Order: Up to a 3 month supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. **Certain drugs may have an authorization requirement or may result in a higher cost. If you use a non-network Pharmacy, you are responsible for any amount over the allowed amount. 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 2 – Your Mid-Range Cost Option	Retail: $35 copay Mail Order: $87.50 copay	Retail: $35 copay Mail Order: Not Covered	
	Tier 3 – Your Highest-Cost Option	Retail: $60 copay Mail Order: $150 copay	Retail: $60 copay Mail Order: Not Covered	
	Tier 4 – Additional High-Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	---------- None ----------
	Physician/surgeon fees	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	---------- None ----------
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	**Notification is required if confined in a non-Network Hospital or benefit reduces to 50%.
	Emergency medical transportation	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	---------- None ----------

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Urgent care	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	---------- None ----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	**Pre-authorization is required non-network or benefit reduces to 50%.
	Physician/surgeon fee	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	---------- None ----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	**Pre-authorization is required non-network or benefit reduces to 50%.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	
	Substance use disorder outpatient services	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	
	Substance use disorder inpatient services	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	
If you are pregnant	Prenatal and postnatal care	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	Network routine pre-natal care is covered at No Charge after initial office visit.
	Delivery and all inpatient services	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	**Pre-authorization is required non-network or benefit reduces to 50%.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	Limited to 60 visits per year. **Pre-authorization is required non-network or benefit reduces to 50%.
	Rehabilitation services	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	Depending on the type of therapy, there is a limit of 20-36 visits per year. **Pre-authorization is required non-network or benefit reduces to 50%.
	Habilitation services	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	Limited to 20 visits per calendar year.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Skilled nursing care	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	Limited to 60 visits per year. **Pre-authorization is required non-network or benefit reduces to 50%.
	Durable medical equipment	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	Prior Authorization is required for Durable Medical Equipment in excess of $1,000. Covers 1 per type of DME (including repair/replacement) every 3 years. **Pre-authorization is required non-network or benefit reduces to 50%.
	Hospice service	20% coinsurance after deductible has been met	40% coinsurance after deductible has been met	**Inpatient pre-authorization is required non-network or benefit reduces to 50%.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

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 (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Cosmetic surgery
- Dental
- Glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- 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– may be covered with limitations
- Hearing aids– 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 the phone number on the back of your ID card. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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.

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:

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 ID card.

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 $3,420
- Patient pays $4,120

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	$3,000
Copays	$200
Coinsurance	$900
Limits or exclusions	$200
Total	$4,120

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

- Amount owed to providers: $5,400
- Plan pays $1,920
- Patient pays $3,480

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	$3,000
Copays	$300
Coinsurance	$100
Limits or exclusions	$80
Total	$3,480

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.