UnitedHealthcare

Out of Area Plan

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, visit avnet.me/spds or call 1-844-518-8072. 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 www.healthcare.gov/sbc-glossary or call 1-844-518-8072 to request a copy.

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 per calendar year. *Deductibles cross-apply	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
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 chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For network provider*: $5,000 Individual / $10,000 Family For out-of-network providers*: $5,000 Individual / $10,000 Family per calendar year *Out-of-pockets cross-apply	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain prior authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	30% coinsurance	Virtual visit - 30% coinsurance after deductible by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	30% coinsurance	30% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or co-insurance may apply.
	Preventive care/screening/ immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	30% coinsurance	Prior Authorization required for certain services or $750 penalty applies.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	30% coinsurance	None

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)	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.welcometouhc.com**	Generic Drugs (Tier 1)	Retail: $15 copay Mail Order: $37.50 copay	Retail: Not covered	Select Preventive Drugs; same copays as non-preventive. Retail $15 max per fill up to 30 days; Mail Order $37.50 max per fill per 90 days
	Preferred brand drugs (Tier 2)	Retail: 30% coinsurance Mail Order: 30% coinsurance Deductible does not apply	Retail: Not covered	Select Preventive Drugs; same coinsurance as non-preventive. Retail $60 max per fill up to 30 days; Mail Order $150 max per fill per 90 days
	Non-preferred brand drugs (Tier 3)	Retail: 30% coinsurance Mail Order: 30% coinsurance Deductible does not apply	Retail: Not covered	Select Preventive Drugs; same coinsurance as non-preventive. Retail $120 max per fill up to 30 days; Mail Order $300 max per fill per 90 days
	Specialty drugs (Tier 4)	Applicable as noted above	N/A	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	30% coinsurance	Prior Authorization required for certain services or $750 penalty applies.
	Physician/surgeon fees	30% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	30% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	30% coinsurance	Prior Authorization required or $750 penalty applies.
	Physician/surgeon fees	30% coinsurance	30% coinsurance	None

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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	30% coinsurance	EAP through Workplace Options is limited to 6 sessions per calendar year. Prior Authorization required for certain services or $750 penalty applies.
	Inpatient services	30% coinsurance	30% coinsurance	Prior Authorization required for inpatient facility or $750 penalty applies.
If you are pregnant	Office visits	30% coinsurance	30% coinsurance	Prior Authorization required for inpatient stays that exceed normal 48 hours for natural delivery or 96 hours for cesarean or $750 penalty applies. Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound)
	Childbirth/delivery professional services	30% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	30% coinsurance	Prior Authorization required for Home Health Care for certain services (skilled nursing by RN or LPN) or $750 penalty applies.
	Rehabilitation services	30% coinsurance	30% coinsurance	None
	Habilitation services	30% coinsurance	30% coinsurance	None
	Skilled nursing care	30% coinsurance	30% coinsurance	Limited to 60 days per calendar year. Prior Authorization required or $750 penalty applies.
	Durable medical equipment	30% coinsurance	30% coinsurance	None

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)	
	Hospice services	30% coinsurance	30% coinsurance	Prior Authorization required before admission for an inpatient stay in a hospice facility or $750 penalty applies.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	No coverage out-of-network.
	Children's glasses	Not covered	Not covered	Child glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Child dental check-up is not covered.

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.)

- Adult routine vision exam (i.e. refraction)
- Cosmetic Surgery
- Dental Care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care

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

- Acupuncture
- Bariatric Surgery – 1 per lifetime
- Chiropractic care – 12 visits per calendar year
- Hearing aids – 2 items every years
- Infertility treatment - $20,000 lifetime max
- Private-duty nursing
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. 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/ 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 on how 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: 1-844-518-8072 or visit www.welcometouhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the 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 1-844-518-8072.

Traditional Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-844-518-8072.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-518-8072.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-844-518-8072 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-518-8072.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-844-518-8072.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-844-518-8072.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-844-518-8072.

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 plan's overall deductible**	**$2,000**
■ **Specialist coinsurance**	**30%**
■ **Hospital (facility) coinsurance**	**30%**
■ **Other coinsurance**	**30%**

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$2,000**
■ **Specialist coinsurance**	**30%**
■ **Hospital (facility) coinsurance**	**30%**
■ **Other coinsurance**	**30%**

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,020**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$2,000**
■ **Specialist coinsurance**	**30%**
■ **Hospital (facility) coinsurance**	**30%**
■ **Other coinsurance**	**30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**