




Select Plus DKSR MOD

Coverage For: Family | Plan Type: PPO



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, call 1-866-633-2446 or visit [welcometouhc.com](http://welcometouhc.com). 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/](http://www.healthcare.gov/sbc-glossary/) or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<u>Network</u> : \$250 Individual / \$750 Family <u>Out-of-Network</u> : \$250 Individual / \$750 Family <u>Deductibles</u> cross apply. Per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive Care Services</u> and categories with a <u>copay</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<u>Network</u> : \$2,250 Individual / \$4,500 Family <u>Out-of-Network</u> : \$6,500 Individual / \$13,000 Family Per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-633-2446 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Specialist visit</u>	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Preventive care/ screening/ immunization</u>	No Charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. No coverage <u>out-of-network</u> .
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Lab Testing: Free Standing/Office: No Charge Hospital: 10% <u>coinsurance</u> , <u>deductible</u> does not apply X-Ray/Diagnostics: 10% <u>coinsurance</u> , <u>deductible</u> does not apply	Lab Testing: Not Covered X-Ray/Diagnostics: 30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> . No coverage <u>out-of-network</u> for lab testing.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

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 need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://welcometouhc.com">welcometouhc.com</a>	Tier 1 - Your Lowest Cost Option	Retail: \$5 <u>copay, deductible</u> does not apply. Mail-Order: \$10 <u>copay, deductible</u> does not apply.	Retail: \$5 <u>copay, deductible</u> does not apply.	<u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail <u>Network Pharmacy</u> . You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. If you use an <u>out-of-network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 - Your Mid-Range Cost Option	Retail: \$25 <u>copay, deductible</u> does not apply. Mail-Order: \$50 <u>copay, deductible</u> does not apply.	Retail: \$25 <u>copay, deductible</u> does not apply.	
	Tier 3 - Your Mid-Range Cost Option	Retail: \$40 <u>copay, deductible</u> does not apply. Mail-Order: \$80 <u>copay, deductible</u> does not apply.	Retail: \$40 <u>copay, deductible</u> does not apply.	
	Tier 4 - Your Highest Cost Option	Retail: \$45 <u>copay, deductible</u> does not apply. Mail-Order: \$90 <u>copay, deductible</u> does not apply.	Retail: \$45 <u>copay, deductible</u> does not apply.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center/ Office: \$150 <u>copay/service</u> , then 10% <u>coinsurance, deductible</u> does not apply Hospital: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Out-of-network allowed amounts</u> for Facility Fees are limited to \$760 per date of service. <u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/ surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	

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 immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> per visit then 10% <u>coinsurance</u> , <u>deductible</u> does not apply	\$150 <u>copay</u> per visit then 10% <u>coinsurance</u> , <u>deductible</u> does not apply	None
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	*10% <u>coinsurance</u>	* <u>Network deductible</u> applies.
	<u>Urgent Care</u>	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Network All Other</u> : 10% <u>coinsurance</u> . Intensive Behavior Therapy (ABA): 10% <u>coinsurance</u> , <u>deductible</u> does not apply. See your policy or <u>plan</u> document for additional information about Employee Assistance Program (EAP) benefits.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . See your policy or <u>plan</u> document for additional information about EAP benefits.
If you are pregnant	Office Visits	No Charge	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Inpatient <u>Preauthorization</u> applies <u>out-of-network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of <u>allowed amount</u> .

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

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 help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 100 visits per calendar year. <u>Out-of-network allowed amounts</u> for <u>Home health care</u> are limited to \$150 per visit. <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<u>Rehabilitation services</u>	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	Outpatient <u>rehabilitation services</u> are unlimited per calendar year. No limits apply for treatment of Autism Spectrum Disorder Services. No coverage <u>out-of-network</u> for physical and occupational therapy.
	<u>Habilitative services</u>	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	Services are provided under <u>Rehabilitation Services</u> above. No limits apply for treatment of Autism Spectrum Disorder Services. No coverage <u>out-of-network</u> for physical and occupational therapy.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Skilled Nursing is limited to 100 days per calendar year. <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not covered	No coverage <u>out-of-network</u> .
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of <u>allowed amount</u> .

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 your child needs dental or eye care	Children's eye exam	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	Not covered	Limited to 1 exam every 24 months. No coverage <u>out-of- network</u> .
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

## 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
- Dental Care
- Glasses
- Long Term Care
- Non-emergency care when traveling outside - the US
- Private duty nursing
- Routine foot care - Except as covered for Diabetes

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

- Acupuncture - 20 visits per calendar year
- Bariatric surgery - 1 procedure per lifetime
- Chiropractic (manipulative) care - 24 visits per calendar year
- Hearing aids - \$2,500 per calendar year
- Infertility Treatment
- Routine eye care (Adult) - 1 exam per 24 months
- Weight loss programs- Real Appeal

**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 Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or [www.dmhc.ca.gov](http://www.dmhc.ca.gov), or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://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](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 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: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

Additionally, a consumer assistance program may help you file your appeal. Contact Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or [www.dmhc.ca.gov](http://www.dmhc.ca.gov).

#### **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 1-866-633-2446.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-633-2446.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-866-633-2446 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2446.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2446.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-633-2446.

*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)

■ <b>The plan's overall deductible</b>	\$250
■ <b>Specialist copay</b>	\$20
■ <b>Hospital (facility) coinsurance</b>	10%
■ <b>Other coinsurance</b>	10%

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<u>Cost Sharing</u>	
<u>Deductibles</u>	<b>\$250</b>
<u>Copayments</u>	<b>\$10</b>
<u>Coinsurance</u>	<b>\$1,000</b>
<i>What isn't covered</i>	
Limits or exclusions	<b>\$60</b>
<b>The total Peg would pay is</b>	<b>\$1,320</b>

### Managing Joe's type 2 Diabetes

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

■ <b>The plan's overall deductible</b>	\$250
■ <b>Specialist copay</b>	\$20
■ <b>Hospital (facility) coinsurance</b>	10%
■ <b>Other coinsurance</b>	10%

**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>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<u>Cost Sharing</u>	
<u>Deductibles</u>	<b>\$200</b>
<u>Copayments</u>	<b>\$300</b>
<u>Coinsurance</u>	<b>\$0</b>
<i>What isn't covered</i>	
Limits or exclusions	<b>\$0</b>
<b>The total Joe would pay is</b>	<b>\$500</b>

### Mia's Simple Fracture

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

■ <b>The plan's overall deductible</b>	\$250
■ <b>Specialist copay</b>	\$20
■ <b>Hospital (facility) coinsurance</b>	10%
■ <b>Other coinsurance</b>	10%

**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>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<u>Cost Sharing</u>	
<u>Deductibles</u>	<b>\$250</b>
<u>Copayments</u>	<b>\$400</b>
<u>Coinsurance</u>	<b>\$200</b>
<i>What isn't covered</i>	
Limits or exclusions	<b>\$0</b>
<b>The total Mia would pay is</b>	<b>\$850</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.