UnitedHealthcare

Signature Plan - CA

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 www.ingrambenefits.com or call 1-800-876-7266. 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 1-866-204-3120 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $500 Individual / $1,000 Family Non-Network: $700 Individual / $1,400 Family per calendar year.	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 with copay 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?	Medical – For Network providers: $2,100 Individual / $4,200 Family For out-of-network providers: $4,150 Individual / $8,300 Family per calendar year	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 pre-notification 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?	Yes. This plan uses Network Select Plus. See www.myuhc.com or call 1-866-204-3120 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
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 Premium Providers All other Network Providers	$15 copay/ visits $25 copay/visit	35% coinsurance	Virtual visit - In network no charge per visit by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. No virtual visit coverage for out of network.
	Specialist visit Premium Providers All other Network Providers	$30 copay/visit $40 copay/visit	35% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. No virtual visit coverage for out-of-network.
	Preventive care/screening/ immunization	No charge	35% coinsurance	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)	No charge	35% coinsurance	Prior Authorization required out-of-network for Sleep Studies or benefit reduces by $500 penalty.

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)	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% coinsurance	None
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.caremark.com**	Generic Drugs (Tier 1)	Retail: $8.00 copay 30-day supply Mail Order: $20.00 copay 90-day supply	Not Covered	To verify the coverage of a medication, please call customer care at 1-800-503-3241, visit www.caremark.com, or download CVS Caremark's mobile app. Maintenance medications are available for 90-day supply at either CVS retail pharmacies, CVS pharmacies within Target, or through mail-order. If applicable, when a brand medication is chosen by you even though a generic equivalent is available under the plan, you will pay a higher copay/coinsurance as well as paying the difference in cost between the brand and generic medication. Medications/Prescription Drugs classified as "Specialty or Limited Distribution" can be obtained through CVS Specialty Pharmacy. Please visit www.cvsspecialty.com or call 1-800-237-2767. These medications will be shipped to your home or local CVS pharmacy for pick up. Certain brand name drugs are subject to step therapy requirements. You can receive up to a 30-day supply at your local participating pharmacy or 90-day supply by mail or at a CVS pharmacy.
	Preferred brand drugs (Tier 2)	30% coinsurance deductible does not apply. Minimum: $25 – 30-day supply, $62.50 – 90-day supply. Maximum: $100 – 30-day supply, $250 – 90-day supply	Not Covered	
	Non-preferred brand drugs (Tier 3)	40% coinsurance deductible does not apply. Minimum: $60 – 30-day supply, $150 – 90-day supply. Maximum: $150 – 30-day supply, $375 – 90-day supply	Not Covered	

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)	
	Specialty drugs (Tier 4)	30% coinsurance $0 out-of-pocket if participating in PrudentRx Program* *Members enrolled in the PrudentRx program have the opportunity to get select specialty drugs at no cost.	Not Covered	$2,500 Annual Out-of-Pocket Maximum. Out-of-Network prescriptions: Member pays full cost and files a paper claim for reimbursement. Member will be reimbursed the discounted cost of the drug, minus the applicable member cost share. Specialty drugs are dispensed exclusively through CVS/Caremark's Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit	35% coinsurance	Prior Authorization required for certain services out-of-network or benefit reduces by $500 penalty.
	Physician/surgeon fees	No charge	35% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$75 copay/visit	35% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	35% coinsurance	Prior Authorization required out-of-network or benefit reduces by $500 penalty.
	Physician/surgeon fees	20% coinsurance	35% 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	$25 copay/visit	35% coinsurance	Prior Authorization required for certain services or benefit reduces by $500 penalty. Partial Hospitalization / Intensive Outpatient Treatment in-network $250 copay per visit and out-of-network 35% coinsurance after deductible. Intensive Behavioral Therapy in-network 20% coinsurance after deductible and out-of-network 35% coinsurance after deductible.
	Inpatient services	20% coinsurance	35% coinsurance	Prior Authorization required out-of-network for inpatient facility or benefit reduces by $500 penalty.
If you are pregnant	Office visits	$25 copay/initial visit only	35% coinsurance	Prior Authorization required out-of-network for Inpatient stays that exceed normal 48 hours for vaginal delivery or 96 hours for cesarean or benefit reduces by $500 penalty. 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	20% coinsurance	35% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	35% coinsurance	

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	Home health care	No charge	35% coinsurance	Prior Authorization required out-of-network for Home Health Care for certain services (skilled nursing by RN or LPN) or benefit reduces by $500 penalty. 60 visit limit per calendar year (combined in-network and out-of-network) applies to physical, speech, occupational therapy provided in the home.
	Rehabilitation services	$15 copay/visit	35% coinsurance	Cardiac Rehabilitation - 36 visit limit; Pulmonary Rehabilitation - 36 visit limit; Occupational Therapy - 30 visit limit; Physical Therapy - 30 visit limit and $15 copay per visit (in-network). All other therapies: 20% coinsurance after deductible (in-network); Speech Therapy - 30 visit limit. Note: All visits are per calendar year
	Habilitation services	20% coinsurance	35% coinsurance	Habilitation Services are provided, and limits are combined with Rehabilitation Services above
	Skilled nursing care	20% coinsurance	35% coinsurance	Prior Authorization required out-of-network or benefit reduces by $500 penalty. 100 day limit applies per calendar year
	Durable medical equipment	20% coinsurance	35% coinsurance	Prior Authorization required out-of-network for DME devices that cost more than $1,000 per device or benefit reduces by $500 penalty.

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	No charge	35% coinsurance	Prior Authorization required out-of-network before admission for an inpatient stay in a hospice facility or benefit reduces by $500 penalty.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Child routine vision exam is not covered.
	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.)

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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

- Bariatric Surgery – 1 surgery per lifetime
- Routine foot care
- Chiropractic care – 30 visits per calendar year
- Hearing aids – 1 per hearing impaired ear every 36 months. Covered only for members under the age of 18.

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: 1-866-204-3120 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? No

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 1-866-204-3120.

Traditional Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-204-3120.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-204-3120.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-204-3120 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-204-3120.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-204-3120.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-204-3120.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-866-204-3120.

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**	**$500**
■ **Specialist copayment**	**$40**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

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	$500
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,870**

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

■ **The plan's overall deductible**	**$500**
■ **Specialist copayment**	**$40**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,600**

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

■ **The plan's overall deductible**	**$500**
■ **Specialist copayment**	**$40**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,010**