



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.uhcsr.com/calarts or call 1-800-767-0700. For general definitions of common terms, such as allowed amount, balance billing, coinsurance (coins), copayment (copay), deductible (ded), provider, or other underlined terms, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-800-767-0700 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Preferred Providers</u> \$150 (Person) Out of Network \$500 (Person)	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.
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> , Pediatric Dental Preventive and Diagnostic Services, Pediatric Vision and categories that specify <u>ded</u> does not apply.	This <u>plan</u> covers some items and services even if you haven't yet met the <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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. Pediatric Dental \$500. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Preferred Providers</u> \$6,000 (Person) <u>Preferred Providers</u> \$7,500 (Family) Out of Network \$12,000 (Person)	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.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.uhcsr.com/calarts or call 1-800-767-0700 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 charge</u> 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.
Do you need a <u>referral</u> to see a <u>specialist</u>?	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
		Preferred 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	\$20 <u>Copay</u> per visit <u>ded</u> does not apply	50% <u>Coins</u>	Does not apply when related to surgery or Physiotherapy.
	<u>Specialist</u> visit	\$20 <u>Copay</u> per visit <u>ded</u> does not apply	50% <u>Coins</u>	
	<u>Preventive care/screening/immunization</u>	No Charge	50% <u>Coins</u>	Includes <u>preventive services</u> specified in the health care reform law or benefits provided as mandated by state law. 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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Imaging</u> (CT/PET scans, MRIs)	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.uhcsr.com/capdl	Tier 1 - Your Lowest-Cost Option	\$10 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply	\$10 <u>Copay</u> per prescription generic drug \$30 <u>Copay</u> per prescription brand-name drug <u>ded</u> does not apply	Preferred Providers: up to a 30 day supply per prescription Preferred Providers: UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply. Out of Network: up to a 30 day supply per prescription You may need to obtain certain <u>specialty drugs</u> from a pharmacy designated by us. You may need to obtain <u>prior authorization</u> for certain <u>prescription drugs</u> .
	Tier 2 - Your Midrange-Cost Option	\$30 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply	\$10 <u>Copay</u> per prescription generic drug \$30 <u>Copay</u> per prescription brand-name drug <u>ded</u> does not apply	
	Tier 3 - Your Highest-Cost Option	\$50 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply	\$10 <u>Copay</u> per prescription generic drug \$30 <u>Copay</u> per prescription brand-name	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			drug <u>ded</u> does not apply	
	Tier 4 - Additional High-Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	Physician/surgeon fees	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>Coins</u> \$150 <u>Copay</u> per visit <u>ded</u> does not apply	20% <u>Coins</u> \$150 <u>Copay</u> per visit <u>ded</u> does not apply	May be limited to use of emergency room and supplies. The <u>Copay</u> will be waived if admitted to the Hospital. Out of Network: (The Insured's expense shall not exceed the amount payable for <u>Preferred Provider</u> Medical Emergency Expenses.)
	<u>Emergency medical transportation</u>	20% <u>Coins</u>	20% <u>Coins</u>	Out of Network: (The Insured's air ambulance expense shall not exceed the amount payable for <u>Preferred Provider</u> air ambulance services.)
	<u>Urgent care</u>	20% <u>Coins</u> \$20 <u>Copay</u> per visit <u>ded</u> does not apply	50% <u>Coins</u>	May be limited to facility fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Miscellaneous Expenses: 20% <u>Coins</u> Room and Board Expense: 20% <u>Coins</u> \$50 <u>Copay</u> per Hospital Confinement <u>ded</u> does not apply	50% <u>Coins</u>	_____none_____
	Physician/surgeon fees	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
If you need mental health, behavioral	Outpatient services	Office Visits: \$20 <u>Copay</u> per visit	Office Visits: 50% <u>Coins</u>	_____none_____

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
health, or substance abuse services		<u>ded</u> does not apply Other: 20% <u>Coins</u>	Other: 50% <u>Coins</u>	
	Inpatient services	20% <u>Coins</u> <u>ded</u> does not apply	50% <u>Coins</u>	_____none_____
If you are pregnant	Office visits	\$20 <u>Copay</u> per visit <u>ded</u> does not apply	50% <u>Coins</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> when provided by a <u>preferred provider</u> . Depending on the type of services, 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 professional services	20% <u>Coins</u>	50% <u>Coins</u>	
	Childbirth/delivery facility services	Hospital Miscellaneous Expenses: 20% <u>Coins</u> Room and Board Expense: 20% <u>Coins</u> \$50 <u>Copay</u> per Hospital Confinement <u>ded</u> does not apply	50% <u>Coins</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coins</u>	50% <u>Coins</u>	100 visits maximum per Policy Year.
	<u>Rehabilitation services</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Habilitation services</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Skilled nursing care</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Durable medical equipment</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Hospice services</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
If your child needs dental or eye care	Children's eye exam	\$20 <u>Copay</u> per exam; <u>ded</u> does not apply	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*
	Children's glasses	Lens: \$40 <u>Copay</u> ; <u>ded</u> does not apply Frames: Tiered	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		<u>Copays</u> from no charge to 40% based on retail cost. <u>ded</u> does not apply		
	Children's dental check-up	No Charge; <u>ded</u> does not apply	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Dental Benefit Details. Age limits apply.*

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
- Routine eye care (Adult)
- Hearing aids
- Routine foot care
- Long-term care
- Weight loss programs

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

- Acupuncture.
- Non-emergency care when traveling outside the U.S.
- Bariatric surgery
- Private-duty nursing
- Chiropractic care

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: California Department of Insurance at 1-800-927-4357 or visit <http://www.insurance.ca.gov/>. 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: California Department of Insurance at 1-800-927-4357 or visit <http://www.insurance.ca.gov/>.

Additionally, a consumer assistance program can help you file your appeal, contact California Department of Insurance Consumer Communications Bureau at 300 South Spring Street, South Tower, Los Angeles, CA 90013 or call 1-800-927-4357 or 1-800-382-4TDDD (4833) or visit <http://www.insurance.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 Minimum Value Standards? Not Applicable

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 1-866-260-2723.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-260-2723.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-260-2723.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-260-2723.

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall <u>deductible</u>	\$150	■ The plan's overall <u>deductible</u>	\$150	■ The plan's overall <u>deductible</u>	\$150
■ <u>Specialist copayment</u>	\$20	■ <u>Specialist copayment</u>	\$20	■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%
This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)		This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$4,800	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<u>Deductibles</u>	\$150	<u>Deductibles</u>	\$150	<u>Deductibles</u>	\$150
<u>Copayments</u>	\$20	<u>Copayments</u>	\$500	<u>Copayments</u>	\$70
<u>Coinsurance</u>	\$2,000	<u>Coinsurance</u>	\$100	<u>Coinsurance</u>	\$500
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$2,230	The total Joe would pay is	\$770	The total Mia would pay is	\$720

UNITEDHEALTHCARE INSURANCE COMPANY

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE PROGRAM

NON-DISCRIMINATION NOTICE

UnitedHealthcare StudentResources does not discriminate or treat Insureds differently on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

If you think you were treated unfairly for any of these reasons, you can send a complaint to:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

If you think you were treated unfairly because of your ancestry, religion, marital status, gender, gender identity, or sexual orientation, you can also send a complaint to the California Department of Insurance:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll-Free Consumer Hotline: 1-800-927-HELP (4357) or 1-213-897-8921
TDD Number: 1-800-482-4TDD (4833)
<http://www.insurance.ca.gov>

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can also file a complaint with the U.S. Dept. of Health and Human Services.

Online <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free **1-800-368-1019, 800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

