UnitedHealthcare®: **Midwestern State University 2018-4011-1**

Coverage Period: 8/1/2018 – 7/31/2019
Coverage for: Student/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, visit www.uhcsr.com 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.cciio.cms.gov or by call 1-800-767-0700 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Providers $500 (Person) Out of Network $1,000 (Person)	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, Pediatric Dental, Pediatric Vision and categories 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?	Yes. Pediatric Dental $500. There are no other specific deductibles.	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.
What is the out–of–pocket limit for this plan?	Preferred Providers $6,350 (Person) Preferred Providers $12,700 (Family) Out of Network $6,350 (Person) Out of Network $12,700 (Family)	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, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.uhcsr.com or call 1-800-767-0700 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
		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	$50 Copay per visit; ded does not apply.	40% Coins	May not apply when related to surgery or Physiotherapy. Student Health Center Benefits: The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred.
	Specialist visit	$50 Copay per visit; ded does not apply	40% Coins	
	Preventive care/screening/immunization	No Charge	40% Coins	Includes preventive services 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 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)	20% Coins	40% Coins	——————none——————
	Imaging (CT/PET scans, MRIs)	20% Coins	40% Coins	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.uhcsr.com/txpdl	Tier 1 - Your Lowest-Cost Option	$25 Copay per prescription Tier 1; ded does not apply	$25 Copay per prescription generic drug; ded does not apply $50 Copay per prescription brand-name drug; ded does not apply	Preferred Providers: up to a 31 day supply per prescription Preferred Providers: Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply Out of Network: up to a 31 day supply per prescription You may need to obtain certain specialty drugs from a pharmacy designated by us.
	Tier 2 - Your Midrange-Cost Option	$50 Copay per prescription Tier 2; ded does not apply	$25 Copay per prescription generic drug; ded does not apply $50 Copay per prescription brand-name drug; ded does not apply	
	Tier 3 - Your Highest-Cost Option	$50 Copay per	$25 Copay per	

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)	
		prescription Tier 3; ded does not apply	prescription generic drug; ded does not apply $50 Copay per prescription brand-name drug; ded does not apply	
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 Copay 20% Coins; ded does not apply	$150 Copay 40% Coins; ded does not apply	——————none——————
	Physician/surgeon fees	20% Coins	40% Coins	——————none——————
If you need immediate medical attention	Emergency room care	20% Coins $200 Copay per visit; ded does not apply	20% Coins $200 Copay per visit; ded does not apply	May be limited to use of emergency room and supplies. The Copay will be waived if admitted to the Hospital.
	Emergency medical transportation	20% Coins	20% Coins	——————none——————
	Urgent care	20% Coins	40% Coins	May be limited to facility fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coins	40% Coins	——————none——————
	Physician/surgeon fees	20% Coins	40% Coins	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Laboratory Procedures: 20% Coins Physician's Visits: $50 Copay per visit; ded does not apply	40% Coins	——————none——————
	Inpatient services	20% Coins	40% Coins	——————none——————
If you are pregnant	Office visits	20% Coins	40% Coins	Cost sharing does not apply for preventive services when provided by a preferred provider. Depending on the type of
	Childbirth/delivery professional services	20% Coins	40% Coins	

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)	
				services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% Coins	40% Coins	————————none————————
If you need help recovering or have other special health needs	Home health care	20% Coins	40% Coins	60 visits maximum (Per Policy Year)
	Rehabilitation services	20% Coins	40% Coins	Outpatient: 35 visits for any combination of physical therapy, occupational therapy, cardiac therapy, and manipulative therapy
	Habilitation services	20% Coins	40% Coins	Outpatient: 35 visits for any combination of physical therapy, occupational therapy, cardiac therapy, and manipulative therapy
	Skilled nursing care	20% Coins	40% Coins	25 days maximum (Per Policy Year)
	Durable medical equipment	20% Coins	40% Coins	————————none————————
	Hospice services	20% Coins	40% Coins	————————none————————
If your child needs dental or eye care	Children's eye exam	$20 Copay per exam; ded does not apply	50% Coins; ded does not apply	See your plan's Pediatric Vision Benefit Details. Age limits apply.*
	Children's glasses	Lens: $40 Copay; ded does not apply Frames: Tiered Copays from no charge to 40% based on retail cost. ded does not apply	50% Coins; ded does not apply	See your plan's Pediatric Vision Benefit Details. Age limits apply.*
	Children's dental check-up	50% Coins	50% Coins	See your plan's 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.)

- Acupuncture
- Cosmetic surgery
- Infertility treatment

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- 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, for morbid obesity only
- Hearing aids, 1 per ear every 36 months
- Chiropractic care
- Dental care (Adult) for Injury to Sound, Natural teeth and removal of complete bony impacted teeth only

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: Texas Department of Insurance at 1-800-252-3439 or visit http://www.tdi.texas.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 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: Texas Department of Insurance at 1-800-252-3439 or visit http://www.tdi.texas.gov/.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-866-260-2723.

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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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)

The plan's overall deductible	$500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	0%

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$70
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,630**

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	$50
Hospital (facility) coinsurance	20%
Other coinsurance	0%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,360**

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

The plan's overall deductible	$500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	0%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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

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NON-DISCRIMINATION NOTICE

UnitedHealthcare StudentResources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, 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.

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

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, 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.

LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-866-260-2723.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：1-866-260-2723.

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-260-2723.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-260-2723.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру 1-866-260-2723.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-866-260-2723.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-260-2723.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-260-2723.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-260-2723.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-260-2723.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-260-2723.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-260-2723 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-260-2723 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.
1-866-260-2723 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-260-2723

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-866-260-2723។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-260-2723.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-260-2723 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-260-2723.