



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 1-888-799-7716. 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 call 1-888-799-7716 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|---|--|
| What is the overall deductible? | <u>Preferred Providers</u> \$500 (Person) <u>Out of Network</u> \$1,000 (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. 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> . |
| Are there services covered before you meet your deductible? | Yes. <u>Preventive care</u> , Pediatric Dental, 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 deductibles 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 out-of-pocket limit for this plan? | <u>Preferred Providers</u> \$7,350 (Person) <u>Out of Network</u> \$15,000 (Person) | The <u>out-of-pocket</u> limit 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 out-of-pocket limit? | <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 network provider? | Yes. See www.uhcsr.com or call 1-888-799-7716 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. |
| Do you need a referral to see a specialist? | 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 | \$30 <u>Copay</u> per visit <u>ded</u> does not apply | 40% <u>Coins</u> | May not apply when related to surgery or Physiotherapy. Student Health Center Benefits (Students Only): The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. |
| | <u>Specialist</u> visit | \$30 <u>Copay</u> per visit <u>ded</u> does not apply | 40% <u>Coins</u> | |
| | <u>Preventive care/screening/immunization</u> | No Charge | 40% <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> | 40% <u>Coins</u> | _____none_____ |
| | Imaging (CT/PET scans, MRIs) | 20% <u>Coins</u> | 40% <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/txpdl | Tier 1 - Your Lowest-Cost Option | \$20 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply | 40% <u>Coins</u> | <u>Preferred Providers</u> : up to a 31 day supply per prescription <u>Preferred Providers</u> : Mail order <u>Prescription Drugs</u> through UHCP at 2.5 times the retail <u>Copay</u> up to a 90 day supply You may need to obtain certain <u>specialty drugs</u> from a pharmacy designated by us. You may need to obtain prior authorization for certain <u>Prescription Drug</u> Products |
| | Tier 2 - Your Midrange-Cost Option | \$60 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply | 40% <u>Coins</u> | |
| | Tier 3 - Your Highest-Cost Option | 80% <u>Coins</u> per prescription Tier 3 <u>ded</u> does not apply | 40% <u>Coins</u> | |
| | Tier 4 - Additional High-Cost Option | Not Covered | Not Covered | |

| 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) | |
| | | | | before being dispensed at a network pharmacy. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| | Physician/surgeon fees | 20% <u>Coins</u> | 40% <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. |
| | <u>Emergency medical transportation</u> | 20% <u>Coins</u> | 20% <u>Coins</u> | _____none_____ |
| | <u>Urgent care</u> | \$50 <u>Copay</u> per visit <u>ded</u> does not apply | 40% <u>Coins</u> | May be limited to facility fees. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| | Physician/surgeon fees | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visits: \$30 <u>Copay</u> per visit <u>ded</u> does not apply Other: 20% <u>Coins</u> | Office Visits: 40% <u>Coins</u> Other: 40% <u>Coins</u> | _____none_____ |
| | Inpatient services | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| If you are pregnant | Office visits | \$30 <u>Copay</u> per visit <u>ded</u> does not apply | 40% <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> | 40% <u>Coins</u> | |
| | Childbirth/delivery facility services | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>Coins</u> | 40% <u>Coins</u> | 60 visits maximum (Per Policy Year) |
| | <u>Rehabilitation services</u> | 20% <u>Coins</u> | 40% <u>Coins</u> | Outpatient: 35 visits of any combination of physical therapy, occupational therapy, cardiac therapy and manipulative therapy. |

| 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>Habilitation services</u> | 20% <u>Coins</u> | 40% <u>Coins</u> | Outpatient: 35 visits of any combination of physical therapy, occupational therapy, cardiac therapy and manipulative therapy. |
| | <u>Skilled nursing care</u> | 20% <u>Coins</u> | 40% <u>Coins</u> | 25 days maximum (Per Policy Year) |
| | <u>Durable medical equipment</u> | 20% <u>Coins</u> | 40% <u>Coins</u> | —————none————— |
| | <u>Hospice services</u> | 20% <u>Coins</u> | 40% <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 <u>Copays</u> from no charge to 40% based on retail cost. <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 dental check-up | 50% <u>Coins</u> | 50% <u>Coins</u> | 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.)

- Acupuncture
- Infertility treatment
- Private-duty nursing
- Weight loss programs
- Bariatric surgery
- Long-term care
- Routine eye care (Adult)
- Cosmetic surgery
- 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.)

- Chiropractic care. Outpatient: 35 visits for any combination of physical therapy, occupational therapy, cardiac therapy, and manipulative therapy
- Dental care (Adult) Injury to Sound Natural Teeth and removal of complete bony impacted teeth only
- Hearing aids, 1 per ear every 36 months

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: UnitedHealthcare StudentResources at 1-888-799-7716 and 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 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, 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 <u>plan's</u> overall <u>deductible</u> | \$500 | ■ The <u>plan's</u> overall <u>deductible</u> | \$500 | ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
| ■ <u>Specialist</u> <u>copayment</u> | \$30 | ■ <u>Specialist</u> <u>copayment</u> | \$30 | ■ <u>Specialist</u> <u>copayment</u> | \$30 |
| ■ 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: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>) | | This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>) | | This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>) | |
| Total Example Cost | \$12,800 | Total Example Cost | \$7,400 | Total Example Cost | \$1,900 |
| 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> | |
| Deductibles | \$500 | Deductibles | \$500 | Deductibles | \$500 |
| Copayments | \$50 | Copayments | \$1,300 | Copayments | \$90 |
| Coinsurance | \$2,000 | Coinsurance | \$200 | Coinsurance | \$100 |
| <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 | \$60 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$2,610 | The total Joe would pay is | \$2,060 | The total Mia would pay is | \$690 |

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

NON-DISCRIMINATION NOTICE

UnitedHealthcare **Student**Resources 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

We 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 toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English

Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian

Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

Amharic

የቋንቋ አርዳታ አገልግሎቶች በነጻ ይገኛሉ። አባከዎ ወደ 1-866-260-2723 ይደውሉ።

Arabic

تتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل على الرقم 1-866-260-2723.

Armenian

Ձեզ մատչելի են անվճար լեզվական օգնություն ծառայություններ: Խնդրում ենք զանգահարել 1-866-260-2723 համարով:

Bantu- Kirundi

Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

Bisayan- Visayan (Cebuano)

Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

Bengali- Bangala

ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

Burmese

ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

Cambodian- Mon-Khmer

សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

Cherokee

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Chinese

您可以免費獲得語言援助服務。請致電 1-866-260-2723。

Choctaw

Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla ho chi apela hinla. I paya 1-866-260-2723.

Cushite- Oromo

Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

Dutch

Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

French

Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

French Creole- Haitian Creole

Gen sèvis ed pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

German

Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

Greek

Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Gujarati

ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કોલ કરો.

Hawaiian

Kōkua manuahi ma kāu ‘ōlelo i loa‘a ‘ia. E kelepona i ka helu 1-866-260-2723.

Hindi

आप के लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

Hmong

Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

Ibo

Enyemaka na-ahazi asusu, bu n'efu, diri gi. Kpoo 1-866-260-2723.

Ilocano

Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

Indonesian

Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

Italian

Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

Japanese

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 までお電話ください。

Karen

ကျိတ်တၢ်စၢၤအကူအညီနီၤသ့ၤလၢတၢ်လိၤဟ့ၣ်အပူၤဘၣ်(ခိၣ်)န့ၣ်လီၤ. ဝံသးစူးဆဲးကျိတ်ဘၣ်1-866-260-2723တက့ၢ်.

Korean

언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

Kru- Bassa

Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yonj. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani

خزمەتگەلی یارمەتی زمانی بەخۆڕای بۆ تۆ دابین دەکەین. تکایە تەلەفۆن بکە بۆ ژمارە 1-866-260-2723.

Laotian

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

