



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 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> \$1,000 (Person) Out of Network \$2,000 (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.
Are there services covered before you meet your <u>deductible</u>?	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 <u>deductibles</u> for specific services?	Yes. Pediatric Dental \$500, and Prescription Drugs \$100. 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> \$8,150 (Person) <u>Preferred Providers</u> \$16,300 (Family) Out of Network \$16,300 (Person) Out of Network \$32,600 (Family)	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 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</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 <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	\$30 <u>Copay</u> per visit <u>ded</u> does not apply	25% <u>Coins</u> \$30 <u>Copay</u> per visit <u>ded</u> does not apply	May not apply when related to surgery or Physiotherapy.
	<u>Specialist</u> visit	\$30 <u>Copay</u> per visit <u>ded</u> does not apply	25% <u>Coins</u> \$30 <u>Copay</u> per visit <u>ded</u> does not apply	
	<u>Preventive care/screening/immunization</u>	No Charge	25% <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)	\$50 <u>Copay</u> per visit	25% <u>Coins</u> \$50 <u>Copay</u> per visit	_____none_____
	Imaging (CT/PET scans, MRIs)	\$50 <u>Copay</u> per visit	25% <u>Coins</u> \$50 <u>Copay</u> per visit	_____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/pdl	Tier 1 - Your Lowest-Cost Option	\$15 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply	50% <u>Coins</u>	<u>Preferred Providers</u> : up to a 31 day supply per prescription <u>Preferred Providers</u> : Mail order
	Tier 2 - Your Midrange-Cost Option	\$30 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply	50% <u>Coins</u>	<u>Prescription Drugs</u> through UHCP at 2.5 times the retail <u>Copay</u> up to a 90 day supply
	Tier 3 - Your Highest-Cost Option	\$60 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply	50% <u>Coins</u>	Out of Network: up to a 31 day supply per prescription You may need to obtain certain <u>specialty drugs</u> from a pharmacy designated by us.
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	<u>Preferred</u> : \$100 Prescription Drug <u>Ded</u>

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com

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)	
				(per Policy Year) does not apply to Policy <u>Ded</u>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	Physician/surgeon fees	Anesthetist Services: 75% of Surgery Allowance Assistant Surgeon Fees: 75% of Surgery Allowance Surgery: 30% <u>Coins</u>	Anesthetist Services: 75% of Surgery Allowance Assistant Surgeon Fees: 75% of Surgery Allowance Surgery: 50% <u>Coins</u>	_____none_____
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>Coins</u> \$200 <u>Copay</u> per visit	30% <u>Coins</u> \$200 <u>Copay</u> per visit	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>	30% <u>Coins</u>	30% <u>Coins</u>	_____none_____
	<u>Urgent care</u>	30% <u>Coins</u>	50% <u>Coins</u>	May be limited to facility fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	Physician/surgeon fees	Anesthetist Services: 75% of Surgery Allowance Assistant Surgeon Fees: 75% of Surgery Allowance Physician's Visits: 30% <u>Coins</u> Surgery: 30% <u>Coins</u>	Anesthetist Services: 75% of Surgery Allowance Assistant Surgeon Fees: 75% of Surgery Allowance Physician's Visits: 50% <u>Coins</u> Surgery: 50% <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: 30% <u>Coins</u>	Office Visits: 25% <u>Coins</u> \$30 <u>Copay</u> per visit <u>ded</u> does not apply Other: 25% <u>Coins</u>	_____none_____
	Inpatient services	30% <u>Coins</u>	50% <u>Coins</u>	_____none_____

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com

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 are pregnant	Office visits	\$30 <u>Copay</u> per visit <u>ded</u> does not apply	25% <u>Coins</u> \$30 <u>Copay</u> per visit <u>ded</u> does not apply	<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	30% <u>Coins</u>	50% <u>Coins</u>	
	Childbirth/delivery facility services	30% <u>Coins</u>	50% <u>Coins</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>Coins</u>	50% <u>Coins</u>	—————none—————
	<u>Rehabilitation services</u>	Inpatient Rehabilitation Facility: 30% <u>Coins</u> Physiotherapy: \$30 <u>Copay</u> per visit <u>ded</u> does not apply No Charge	Inpatient Rehabilitation Facility: 50% <u>Coins</u> Physiotherapy: 25% <u>Coins</u> \$30 <u>Copay</u> per visit <u>ded</u> does not apply	Outpatient: 30 visits for any combination of physical therapy, occupational therapy, and speech therapy Outpatient: 30 visits of manipulative therapy Outpatient: Separate physical, occupational and speech therapy limits apply to rehabilitative and Habilitative Services
	<u>Habilitation services</u>	\$30 <u>Copay</u> per visit <u>ded</u> does not apply	25% <u>Coins</u> \$30 <u>Copay</u> per visit <u>ded</u> does not apply	Outpatient: 30 visits for any combination of physical therapy, occupational therapy, and speech therapy Outpatient: 30 visits of manipulative therapy Outpatient: Separate physical, occupational and speech therapy limits apply to rehabilitative and Habilitative Services
	<u>Skilled nursing care</u>	30% <u>Coins</u>	50% <u>Coins</u>	—————none—————
	<u>Durable medical equipment</u>	30% <u>Coins</u>	30% <u>Coins</u>	—————none—————
	<u>Hospice services</u>	Paid as any other Sickness	Paid as any other Sickness	—————none—————

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com

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 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.*

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com

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
- Dental care (Adult)
- Long-term care
- Weight loss programs
- Bariatric surgery
- Hearing aids except as specifically provided in the policy
- Routine eye care (Adult) except as specifically provided in the policy
- Cosmetic surgery
- Infertility treatment except as specifically provided in the policy
- 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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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: Arkansas Insurance Department at 1-501-371-2640 or 1-800-852-5494 or visit <http://www.insurance.arkansas.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: Arkansas Insurance Department at 1-501-371-2640 or 1-800-852-5494 or visit <http://www.insurance.arkansas.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, 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 overall deductible</u>	\$1,000	■ The <u>plan's overall deductible</u>	\$1,000	■ The <u>plan's overall deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$30	■ <u>Specialist copayment</u>	\$30	■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	30%	■ Hospital (facility) <u>coinsurance</u>	30%	■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%	■ Other <u>coinsurance</u>	30%	■ Other <u>coinsurance</u>	30%
<p>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>)</p>		<p>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>)</p>		<p>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>)</p>	
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	\$1,000	Deductibles	\$1,000	Deductibles	\$1,000
Copayments	\$50	Copayments	\$1,000	Copayments	\$90
Coinsurance	\$2,800	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	\$3,910	The total Joe would pay is	\$2,260	The total Mia would pay is	\$1,190

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

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.

Marathi

भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे.
त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese

Kwomaroñ bōk jebal in jipañ in kajin ilo ejjelōk wōñāñ. Jouj im kallōk 1-866-260-2723.

Micronesian- Pohnpeian

Mic sawas en mahsen ong komwi, soh isepe. Melau eker 1-866-260-2723.

Navajo

Saad bee aka'e'eyeed bee aka'nida'wo'igii t'aa' jiik'eh bee nich'i bee na'hoo'ii. T'aa' shōqdi kohji' 1-866-260-2723 hodii'lih.

Nepali

भाषा सहायता सेवाहरु नि:शुल्क उपलब्ध छन्। कृपया
1-866-260-2723 मा कल गर्नुहोस्।

Nilotic-Dinka

Kāk ē kuny ajuer ē thok atō tīnē yīn abac tē cīn wēu yeke thiēē. Yīn cōl 1-866-260-2723.

Norwegian

Du kan få gratis språkhjelp. Ring 1-866-260-2723.

Pennsylvania Dutch

Schprooch iwesetze Hilf kannscht du frei hawwe. Ruf 1-866-260-2723.

Persian-Farsi

خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره
1-866-260-2723 تماس بگیرید.

Polish

Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

Portuguese

Oferecemos serviço gratuito de assistência de idioma. Ligue para 1-866-260-2723.

Punjabi

ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਜੁਗਾੜੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ
1-866-260-2723 'ਤੇ ਕਾਲ ਕਰੋ।

Romanian

Vi se pun la dispozitie, în mod gratuit, servicii de traducere. Vă rugăm să sunați la 1-866-260-2723.

Russian

Языковые услуги предоставляются вам бесплатно. Звоните по телефону 1-866-260-2723.

Samoan- Fa'asamoa

O loo maua fesoasoani mo gagana mo oe ma e le totogia.
Faamolemole telefoni le 1-866-260-2723.

Serbo- Croatian

Možete besplatno koristiti usluge prevodioca. Molimo nazovite 1-866-260-2723.

Somali

Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa.
Fadlan wac 1-866-260-2723.

Spanish

Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

Sudanic- Fulfulde

B woodi walliinde dow wolde caahu ngam maada. Noodu 1-866-260-2723.

Swahili

Huduma za msaaada wa lugha zinapatikana kwa ajili yako bure.
Tafadhali piga simu 1-866-260-2723.

Syriac- Assyrian

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1-866-260-2723 ܕܘܫܘܒܐ ܕܘܫܘܒܐ

Tagalog

Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng walang bayad. Mangyaring tumawag sa 1-866-260-2723.

Telugu

భాషా సహాయత సేవలు ని:శుల్క ముందుగా అందుబాటులో ఉన్నాయి.
దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

Thai

บริการความช่วยเหลือด้านภาษาไทยโดยที่คุณไม่ต้องเสียค่าใช้จ่าย
แต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข
1-866-260-2733

Tongan- Fakatonga

'Oku 'i ai pō 'a e sōvesi ki he lea' ke tokoni kiate koe pea 'oku
'ata' ia ma'au 'o 'ikai ha totongi. Kātaki 'o tā ki he
1-866-260-2723.

Trukese (Chuukese)

En mei tongeni angei anisin emon chen chialcku, ese kamo.
Kose mochen kopwe kokkori 1-866-260-2723.

Turkish

Dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen
1-866-260-2723 numarayı arayınız.

Ukrainian

Послуги перекладу надаються вам безкоштовно. Дзвоніть за
номером 1-866-260-2723.

Urdu

زبان کے حوالے سے معاونتی خدمات آپ کے لیے بلا معاوضہ دستیاب ہیں۔
برہم رسانی 1-866-260-2723 پر کال کریں۔

Vietnamese

Dịch vụ hỗ trợ ngôn ngữ, miễn phí, dành cho quý vị. Xin vui
lòng gọi 1-866-260-2723.

Yiddish

שפראך הילף סערוויסעס זענען אומגעלעבט פאר אײך פריי פון אפצאל. 1-866-260-2723
ברענגט.

Yoruba

Isẹ iranlọwọ èdè tí ọ jẹ ọfẹ, wá fún ọ. Pe 1-866-260-2723.