




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/agnesscott](http://www.uhcsr.com/agnesscott) 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.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-767-0700 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Preferred Providers \$250 / (Person) Out-of-Network Provider \$600 / (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.
<b>Are there services covered before you meet your deductible?</b>	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	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.
<b>What is the out-of-pocket limit for this plan?</b>	Preferred Providers \$7,500 / (Person) Preferred Providers \$13,700 / (Family) Out-of-Network Provider \$15,000 / (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.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, <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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.uhcsr.com/agnesscott">www.uhcsr.com/agnesscott</a> 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.
<b>Do you need a referral to see a specialist?</b>	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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	20% <u>Coins</u> \$25 <u>Copay</u> /per visit <u>ded</u> does not apply	40% <u>Coins</u>	May not apply when related to surgery or Physiotherapy. <b>Student Health Center Benefits:</b> 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. Policy Exclusions and Limitations do not apply.  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.
	<u>Specialist visit</u>	20% <u>Coins</u> \$25 <u>Copay</u> /per visit <u>ded</u> does not apply	40% <u>Coins</u>	
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	
<b>If you have a test</b>	<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_____
<b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.uhcsr.com/pdl">www.uhcsr.com/pdl</a>	Tier 1 - Your Lowest-Cost Option	\$25 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply	\$25 <u>Copay</u> per prescription generic drug \$45 <u>Copay</u> per prescription brand-name drug <u>ded</u> does not apply	<u>Preferred Providers</u> : up to a 31-day supply per prescription <u>Preferred Providers</u> : Mail Order <u>Network Pharmacy</u> or Preferred 90 Day Retail <u>Network Pharmacy</u> at 2.5 times the retail <u>Copay</u> up to a 90-day supply
	Tier 2 - Your Midrange-Cost Option	\$60 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply	\$25 <u>Copay</u> per prescription generic drug \$45 <u>Copay</u> per prescription brand-name drug <u>ded</u> does not apply	<u>Out-of-Network Provider</u> : up to a 31-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> .

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)	
	Tier 3 - Your Highest-Cost Option	\$75 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply	\$25 <u>Copay</u> per prescription generic drug \$45 <u>Copay</u> per prescription brand-name drug <u>ded</u> does not apply	You may pay more if <u>prior authorization</u> is not obtained.
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	
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>	20% <u>Coins</u> \$50 <u>Copay</u> /per visit <u>ded</u> does not apply	20% <u>Coins</u> \$50 <u>Copay</u> /per visit <u>ded</u> does not apply	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: 20% <u>Coins</u> \$25 <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	20% <u>Coins</u> \$25 <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
	Childbirth/delivery professional services	20% <u>Coins</u>	40% <u>Coins</u>	

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)	
				include tests and services described elsewhere in the SBC (i.e., ultrasound).
	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>	_____none_____
	<u>Rehabilitation services</u>	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____
	<u>Habilitation services</u>	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____
	<u>Skilled nursing care</u>	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____
	<u>Durable medical equipment</u>	20% <u>Coins</u>	20% <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	30% <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	30% <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	40% <u>Coins</u>	40% <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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) except as specifically provided in the policy
- Hearing aids except as specifically provided in the policy
- Infertility treatment
- Routine eye care (Adult)
- Routine foot care except as specifically provided in the policy
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Long-term care except as specifically provided in the policy
- 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: UnitedHealthcare Student Resources at 1-800-767-0700 and Georgia Office of Insurance & Safety Fire Commissioner at 1-800-656-2298 or visit <http://www.oci.ga.gov/consumerservices/home.aspx>. 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](http://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: Georgia Office of Insurance & Safety Fire Commissioner at 1-800-656-2298 or visit <http://www.oci.ga.gov/consumerservices/home.aspx>.

**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): 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)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist</u> <u>copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

#### 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*)

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist</u> <u>copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist</u> <u>copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$12,700
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#### In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$2,500
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,840</b>

Total Example Cost	\$5,600
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#### In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,570</b>

Total Example Cost	\$2,800
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#### In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$400
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,050</b>

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](mailto: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: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/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.





