



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.healthcare.gov/sbc-glossary/ 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 Provider</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. |
| 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> \$8,500 / (Person) <u>Out-of-Network Provider</u> \$22,000 / (Person) | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. |
| 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 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 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 | \$25 <u>Copay</u> /per visit <u>ded</u> does not apply | 40% <u>Coins</u> | Student Health Center Benefits: The Deductible will be waived when treatment is rendered at Methodist Family Health Center-South Grand Prairie. May not apply when related to surgery or Physiotherapy. 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</u> visit | \$25 <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> | |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| | <u>Imaging</u> (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 prescription drug coverage is available at www.uhcsr.com/txpdl | Tier 1 - Your Lowest-Cost Option | \$25 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply | 40% <u>Coins</u> \$25 <u>Copay</u> per prescription generic drug | <u>Preferred Providers:</u> up to a 31 day supply per prescription <u>Preferred Providers:</u> Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail <u>Copay</u> up to a 90-day supply <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> . You may pay more if <u>prior authorization</u> is not obtained. For insulin drugs, the total amount of |
| | Tier 2 - Your Midrange-Cost Option | \$50 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply | \$50 <u>Copay</u> per prescription brand-name drug | |
| | Tier 3 - Your Highest-Cost Option | \$75 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply | <u>ded</u> does not apply | |
| | 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) | |
| | | | | Copays or Coins shall not exceed \$25 for an individual prescription of up to a 30-day supply. |
| 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> | \$100 <u>Copay</u> /per visit 20% <u>Coins</u> <u>ded</u> does not apply | \$100 <u>Copay</u> /per visit 20% <u>Coins</u> <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. If the Injury or Sickness does not meet the definition of a Medical Emergency (page 27), benefits will be paid at 60% of <u>Allowed Amount</u> . |
| | <u>Emergency medical transportation</u> | 20% <u>Coins</u> | 20% <u>Coins</u> | _____none_____ |
| | <u>Urgent care</u> | 20% <u>Coins</u> | 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: \$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_____ |

| 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 | \$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 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> | |
| 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> | 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.* |

*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
- Long-term care
- Weight loss programs
- Cosmetic surgery
- Routine eye care (Adult)
- Infertility treatment
- Routine foot care

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

- Bariatric surgery
- Hearing aids, 1 per ear every 36 months
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Dental care (Adult) Injury to Sound, Natural Teeth and removal of complete bony impacted teeth only
- 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 1-888-799-7716 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 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: Texas Department of Insurance at 1-800-252-3439 or visit <http://www.tdi.texas.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): 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 overall deductible</u> | \$500 |
| ■ <u>Specialist copayment</u> | \$25 |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other 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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$30 |
| <u>Coinsurance</u> | \$1,900 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,490 |

Managing Joe's Type 2 Diabetes

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

| | |
|--|-------|
| ■ The <u>plan's overall deductible</u> | \$500 |
| ■ <u>Specialist copayment</u> | \$25 |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$1,000 |
| <u>Coinsurance</u> | \$100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,620 |

Mia's Simple Fracture

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

| | |
|--|-------|
| ■ The <u>plan's overall deductible</u> | \$500 |
| ■ <u>Specialist copayment</u> | \$25 |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other 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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$300 |
| <u>Coinsurance</u> | \$300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,100 |

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: <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.

