UnitedHealthcare®

Choice In-Network Plan

⚠	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 https://humanresources.columbia.edu or call 1-212-851-7000. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-212-851-7000 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $0 Individual / $0 Family Non-Network: Not Covered	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive Care and primary care services with copay are covered before you meet your deductible.	See the Common Medical Events Chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For Network provider: $3,500 Individual / $7,000 Family per calendar year For Non-Network providers: Not Covered	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, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket.
Will you pay less if you use a network provider?	Yes. See www.columbia.welcometouhc.com or www.myuhc.com or call 1-800-232-9357 for a list of network providers. There is no coverage for Non-Network providers, except as outlined in the Common Medical Events chart.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. Out-of-Network not covered. 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.

Important Questions	Answers	Why This Matters:
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
		Network 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 copay/visit	Not covered	UHC Virtual visit - In network $30 copay per visit by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays may apply. Other Telehealth providers are covered in network at applicable copay.
	Specialist visit	$30 copay/visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	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. Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	$150 copay applies to outpatient hospital facility. No copay for NYP/Columbia or NYP/Weill Cornell Medical Centers.
	Imaging (CT/PET scans, MRIs)	$150 copay/test	Not covered	$150 copay applies to outpatient hospital facility. No copay for NYP/Columbia or NYP/Weill Cornell Medical Centers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	**Out-of-Network Provider** (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myuhc.com	Generic Drugs	Retail: $10 copay Mail Order: $15 copay	Retail: Not covered	Generic, 30 day supply retail; 90 day supply mail order. Certain preventive medications (including contraceptives) are covered at No Charge.
	Preferred Drugs	Retail: $25 copay Mail Order: $50 copay	Retail: Not covered	Single-source brand, 30 day supply retail; 90 day supply mail order
	Non-Preferred Drugs	Retail: $45 copay Mail Order: $90 copay	Retail: Not covered	Multi-source brand, 30 day supply retail; 90 day supply mail order
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Emergency room copay waived if admitted.
	Emergency medical transportation	No charge	No charge	Non-emergency transportation not covered except for medical necessity. Prior authorization required for non-emergency air ambulance or benefit will not be covered.
	Urgent care	$30 copay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit	Not covered	Employee Assistance Program (EAP) up to 6 sessions per subject 100%.
	Inpatient services	$500 copay/visit	Not covered	None
If you are pregnant	Office visits	$30 copay/initial visit only	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	**Out-of-Network Provider** (You will pay the most)	
	Childbirth/delivery professional services	No charge	Not covered	Routine pre-natal care is covered at No Charge. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	$500 copay/visit	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Home health care 200 visits per calendar year. Private duty nursing $5,000 per calendar year. One visit equals four hours of Skilled Care services.
	Rehabilitation services	$30 copay/visit	Not covered	Physical, Occupational combined 60 visits per calendar year. Cardiac, Cognitive, Pulmonary, Speech 60 visits each per calendar year.
	Habilitation services	Not covered	Not covered	Not Covered
	Skilled nursing care	No charge	Not covered	Limit 120 days per calendar year.
	Durable medical equipment	No charge	Not covered	None
	Hospice services	No charge	Not covered	Limit 6 months per lifetime.
If your child needs dental or eye care	Children's eye exam	$10 copay/visit	Not covered	Adult/child under 19: Exam 100% after $10 copay. Limit 1 exam per 12 months.
	Children's glasses	No charge	Not covered	Child under 19: Lenses or 1 pair/box contacts 100%. Frames up to $100 at 100%, 60% thereafter. Limit 1 per 12 months. Adults max: $20 single, $30 bifocal, $40 trifocal, $75 lenticular, $75 contacts, $30 frames. Limit 1 per 24 months.
	Children's dental check-up	Not covered	Not covered	Not Covered

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.)		
• Cosmetic Surgery • Dental Care Adult & Child • Habilitation services	• Long-term care • Non-emergency care when traveling outside the U.S.	• 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.)		
• Acupuncture • Adult routine vision exam (i.e. refraction) • Bariatric Surgery	• Chiropractic care • Hearing aids	• Infertility treatment • 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. 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: 1-800-232-9357 or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 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 1-212-851-7000.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-212-851-7000.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-212-851-7000.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-212-851-7000.
──────────────*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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby		Managing Joe's type 2 Diabetes		Mia's Simple Fracture	
(9 months of in-<u>network</u> pre-natal care and a hospital delivery)		(a year of routine in-<u>network</u> care of a well-controlled condition)		(in-<u>network</u> emergency room visit and follow up care)	
■ The <u>plan's</u> overall <u>deductible</u>	$0	■ The <u>plan's</u> overall <u>deductible</u>	$0	■ The <u>plan's</u> overall <u>deductible</u>	$0
■ <u>Specialist copayment</u>	$30	■ <u>Specialist copayment</u>	$30	■ <u>Specialist copayment</u>	$30
■ <u>Hospital (facility) copayment</u>	$500	■ <u>Hospital (facility) copayment</u>	$500	■ <u>Hospital (facility) copayment</u>	$500
■ Other <u>coinsurance</u>	0%	■ Other <u>coinsurance</u>	0%	■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Peg	Joe	Mia
<u>Specialist</u> office visits *(pre-natal care)* Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests *(ultrasounds and blood work)* <u>Specialist</u> visit *(anesthesia)*	<u>Primary care physician</u> office visits *(including disease education)* Diagnostic tests *(blood work)* <u>Prescription drugs</u> <u>Durable medical equipment</u> *(glucose meter)*	<u>Emergency room care</u> *(including medical supplies)* <u>Diagnostic test</u> *(x-ray)* <u>Durable medical equipment</u> *(crutches)* <u>Rehabilitation services</u> *(physical therapy)*

Total Example Cost	$12,700	Total Example Cost	$5,600	Total Example Cost	$2,800
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$0	Deductibles	$0	Deductibles	$0
Copayments	$500	Copayments	$1,000	Copayments	$400
Coinsurance	$0	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$20	Limits or exclusions	$0
The total Peg would pay is	**$560**	**The total Joe would pay is**	**$1,020**	**The total Mia would pay is**	**$400**

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services

We do 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 the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the 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 number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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 provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

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 số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 **(Korean)** 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer 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。
本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリー
ダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of SBC ،Benefits and Coverage) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្ដីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).