



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at hbe.sandia.gov or by calling 1-877-835-9855.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: \$750 Individual / \$2,250 Family Non-Network: \$2,000 Individual / \$6,000 Family Per calendar year. Does not apply to pharmacy drugs, and services listed below as “No Charge”.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No, there are no other deductibles .	You don’t have to meet deductibles for specific service, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Medical- Network: \$2,250 Individual / \$6,750 Family Non-Network: \$6,000 Individual / \$18,000 Family Prescription Drugs - Network: \$1,500 Individual / \$5,950 Family Non-Network: \$1,500 Individual / \$5,950 Family	The out-of-pocket limit is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums , balanced-billed charges, health care this plan doesn’t cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don’t count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes, this plan uses network providers . If you use a non-network provider your cost may be more. For a list of network providers , see www.myuhc.com or call 1-877-835-9855.	If you use a network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn’t cover?	Yes	Some of the services this plan doesn’t cover are listed on Page 6. See your policy or plan document for additional information about excluded services .

Questions: Call 1-877-835-9855 or visit us at hbe.sandia.gov. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call the number above to request a copy.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Employee/Family | Plan Type: PS1



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Virtual visit - In network 20% co-insurance after deductible by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-insurance may apply.
	Specialist visit	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Other practitioner office visit	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Cost Share applies for only Manipulative (Chiropractic) Care. \$750/calendar year In/Out-Network combined maximum benefit.
	Preventive care/screening/immunization	No Charge	40% Coinsurance After Deductible	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Prior Authorization required Out-of-Network for Sleep Studies or benefit will be reduced by \$300.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.express-scripts.com.</p>	Generic	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Retail: 50% Coinsurance	Retail: member pays 20% (min \$5/max \$10); Mail Order: member pays 20% (min \$12.50/max \$25)
	Preferred Brand	Retail: 30% Coinsurance Mail Order: 30% Coinsurance	Retail: 50% Coinsurance	Retail: member pays 30%; (min \$25/max \$40); Mail Order: member pays 30% (min \$62.50/max \$100)
	Non-Preferred Brand	Retail: 40% Coinsurance Mail Order: 40% Coinsurance	Retail: 50% Coinsurance	Retail: member pays 40%; (min \$40/max \$60); Mail Order: member pays 40% (min \$100/max \$150)
	Tier 4 - Additional High-Cost Option	Retail: N/A Mail Order: N/A	Retail: N/A Mail Order: N/A	Retail: 30 day supply; Mail Order: 90 day supply. OTC medications with exception required by ACA ; fertility meds, nutritional supplements; drugs for cosmetic purposes
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Physician/surgeon fees	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
<p>If you need immediate medical attention</p>	Emergency room services	20% Coinsurance After Deductible	20% Coinsurance After Deductible	None
	Emergency medical transportation	20% Coinsurance After Deductible	20% Coinsurance After Deductible	None
	Urgent care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Prior Authorization required Out-of-Network or benefit will have \$300 penalty applied.
	Physician/surgeon fee	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Mental/Behavioral health inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Prior Authorization required Out-of-Network or benefit will have \$300 penalty applied.
	Substance use disorder outpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Substance use disorder inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Prior Authorization required Out-of-Network or benefit will have \$300 penalty applied.
If you are pregnant	Prenatal and postnatal care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Your cost in this category includes physician delivery charges. Routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Your cost for inpatient services only. For physician delivery charges, see pre/postnatal care. Prior Authorization required for stays that exceed standard delivery time frames or benefit will have \$300 penalty applied.

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Prior Authorization required Out-of-Network for Home healthcare, private duty nursing, nutrition or benefit will have \$300 penalty applied.
	Rehabilitation services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Habilitation services	Not Covered	Not Covered	No coverage.
	Skilled nursing care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Prior Authorization required Out-of-Network for Skilled Nursing, private duty nursing or benefit will have \$300 penalty applied.
	Durable medical equipment	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Prior Authorization required Out-of-Network for Prosthetic devices that cost more than \$1,000 per device (Purchase or cumulative rental) or benefit will have \$300 penalty applied.
	Hospice service	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Prior Authorization required Out-of-Network for Hospice IP Only or benefit will have \$300 penalty applied.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Eye exam only for non-refractive care due to illness or injury to eye.
	Glasses	Not Covered	Not Covered	Refer to Vision plan information.
	Dental check-up	Not Covered	Not Covered	Refer to Delta Dental plan information.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Child dental check-up • Child routine vision exam (i.e. refraction) • Child vision glasses • Cosmetic Surgery 	<ul style="list-style-type: none"> • Dental Care (Adult) • Habilitation services • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Weight loss programs • Routine Foot Care • Wigs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> • Acupuncture limitations may apply 	<ul style="list-style-type: none"> • Chiropractic care limitations may apply 	<ul style="list-style-type: none"> • Private-duty nursing limitations may

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<ul style="list-style-type: none"> • Adult routine vision exam (i.e. refraction) • Bariatric Surgery limitations may apply 	<ul style="list-style-type: none"> • Hearing aids limitations may apply • Infertility treatment limitations may apply 	<ul style="list-style-type: none"> • apply • Routine foot care limitations may apply
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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-0048. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us at 1-877-835-9855 or visit www.myuhc.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-877-835-9855.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-835-9855.
- Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-835-9855.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-835-9855.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*-----

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$5,330
- Patient pays: \$2,210

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$750
Copays	\$0
Coinsurance	\$1,310
Limits or exclusions	\$150
Total	\$2,210

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays: \$3,670
- Patient pays: \$1,730

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$750
Copays	\$0
Coinsurance	\$900
Limits or exclusions	\$80
Total	\$1,730

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example Show

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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UnitedHealthcare 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 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 877-835-9855, 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 877-835-9855 TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 877-835-9855.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 877-835-9855.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：877-835-9855。

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 877-835-9855.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 877-835-9855 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 877-835-9855.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру 877-835-9855.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 877-835-9855.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 877-835-9855.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 877-835-9855.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniłiśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 877-835-9855.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 877-835-9855.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 877-835-9855.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 877-835-9855 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。877-835-9855 にお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.
877-835-9855 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर काल करें 877-835-9855

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 877-835-9855.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ **khmer (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 877-835-9855។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 877-835-9855.

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 shoodí kohji' 877-835-9855 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 877-835-9855.