UnitedHealthcare

# NUSS & 1199 East Medical Assistants Choice Plus 90 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 www.healthcare.gov/sbc-glossary or call 1-212-851-7000 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network*: $400 per Individual per calendar year<br>Out-of-Network*: $850 per Individual per calendar year. *Deductibles cross-apply Out-of-Network to Network. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **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. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| **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*: $3,250 Individual / $6,500 Family<br>For Out-of-Network providers*: $5,250 Individual / $10,500 Family per calendar year<br>*Out-of-pockets cross-apply Out-of-Network to Network. | 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, penalties for failure to obtain prior authorization for services. | Even though you pay these expenses, they don't count toward the out-of-pocket. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See www.whyuhc.com/columbia or www.myuhc.com or call 1-800-232-9357 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). 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. |
| **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 | 40% coinsurance | 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, deductibles or coinsurance may apply. Other Telehealth providers are covered in network and out-of-network at applicable copay, deductible and coinsurance. |
| | Specialist visit | $30 copay/visit | 40% coinsurance | If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply. Other Telehealth providers are covered in network and out-of-network at applicable copay, deductible and coinsurance. |

| 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) | |
| | Preventive care/screening/ immunization | No charge | 40% coinsurance | 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) | 10% coinsurance | 40% coinsurance | Out-of-Network pre-authorization required for certain services or $500 penalty. |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 40% coinsurance | None |
| **If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myuhc.com** | Tier 1 – Lower cost Generic and some brand name Drugs | Retail: $10 copay Mail Order: $15 copay | Retail: Not covered | 30 day retail; 90 day mail. Certain preventive medications (including contraceptives) are covered at No Charge. |
| | Tier II – Mid range cost Preferred brand name Drugs | Retail: $25 copay Mail Order: $50 copay | Retail: Not covered | 30 day retail; 90 day mail |
| | Tier III – Higher cost Brand name and some generics | Retail: $45 copay Mail Order: $90 copay | Retail: Not covered | 30 day retail; 90 day mail |
| | | | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 40% coinsurance | Out-of-Network pre-authorization required or $500 penalty. |
| | Physician/surgeon fees | 10% coinsurance | 40% coinsurance | Out-of-Network pre-authorization required or $500 penalty. |
| **If you need immediate medical attention** | Emergency room care | $150 copay/visit | $150 copay/visit | Copay waived if admitted. If admitted, out-of-network pre-authorization required or $500 penalty. |

| 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) | |
| | Emergency medical transportation | No charge | No charge | Non-Emergency ground and air transportation provided by a licensed professional ambulance is covered as UHC determines appropriate. Out-of-Network pre-authorization required for non-emergency transportation or $500 penalty. |
| | Urgent care | $30 copay/visit | $30 copay/visit | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 40% coinsurance | Out-of-Network pre-authorization required or $500 penalty. |
| | Physician/surgeon fees | 10% coinsurance | 40% coinsurance | Out-of-Network pre-authorization required or $500 penalty. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copay/visit | 30% coinsurance | Employee Assistance Program (EAP) up to 6 sessions per subject covered at No Charge. Pre-authorization required out of network for certain services or $500 penalty. Partial Hospitalization/Intensive Outpatient Treatment In- Network 10% coinsurance after deductible. Intensive Behavioral Therapy (ABA) In-Network 10% coinsurance no deductible. |
| | Inpatient services | 10% coinsurance | 40% coinsurance | Out-of-Network pre-authorization required or $500 penalty. |
| **If you are pregnant** | Office visits | $30 copay/initial visit only | 40% coinsurance | |
| | Childbirth/delivery professional services | 10% coinsurance | 40% coinsurance | |

| 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 facility services | 10% coinsurance | 40% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound). Out-of-Network pre-authorization required for stays over 48 hours normal or 96 hours cesarean or $500 penalty. |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 40% coinsurance | Home health care 200 visits, outpatient private duty nursing $5,000/ calendar year combined in-network/out of network. One visit equals four hours of Skilled Care services. Out-of-Network pre-authorization required or $500 penalty. |
| | Rehabilitation services | $30 copay/visit | 40% coinsurance | Physical, Occupational combined 60 visits/calendar year. Cardiac, Cognitive, Pulmonary, Speech 60 visits each/calendar year. Combined in-network/out of network. |
| | Habilitation services | Not covered | Not covered | Habilitation Services are not covered. |
| | Skilled nursing care | 10% coinsurance | 40% coinsurance | 120 days/ calendar year combined in-network/out of network. Out-of-Network pre-authorization required or $500 penalty. |
| | Durable medical equipment | 10% coinsurance | 40% coinsurance | In Office: 100% in-network. |

| 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) | |
| | Hospice services | 10% coinsurance | 40% coinsurance | 6 months/lifetime combined in-network/out of network. Out-of-Network pre-authorization required for Inpatient or $500 penalty. |
| **If your child needs dental or eye care** | Children's eye exam | $10 copay/visit | $10 copay/visit | Child under 19: $10 copay/visit. Limit 1 exam per 12 months. |
| | Children's glasses | No charge | No charge | Child under 19: lenses or 1 pair/box contacts 100%. Frames up to $100 at 100%, 60% thereafter. Limit 1 per 12 months. |
| | Children's dental check-up | Not covered | Not covered | Child dental check up is 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)
- 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 20 visits/calendar year
- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Chiropractic care 60 visits/calendar year
- Hearing aids
- Infertility treatment $30,000/Lifetime
- 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.

Traditional 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.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-212-851-7000 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-212-851-7000.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-212-851-7000.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-212-851-7000.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 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 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 plan's overall deductible** | **$400** |
| ■ **Specialist copayment** | **$30** |
| ■ **Hospital (facility) coinsurance** | **10%** |
| ■ **Other coinsurance** | **10%** |

**This EXAMPLE event includes services like:**
Specialist office visits *(pre-natal 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $400 |
| Copayments | $10 |
| Coinsurance | $1,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,670** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| ■ **The plan's overall deductible** | **$400** |
| ■ **Specialist copayment** | **$30** |
| ■ **Hospital (facility) coinsurance** | **10%** |
| ■ **Other coinsurance** | **10%** |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $1,000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,120** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| ■ **The plan's overall deductible** | **$400** |
| ■ **Specialist copayment** | **$30** |
| ■ **Hospital (facility) coinsurance** | **10%** |
| ■ **Other coinsurance** | **10%** |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $200 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$600** |

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