



Dear Customer,

The Affordable Care Act requires all health plan issuers and group health plans to provide eligible employees with a Summary of Benefits and Coverage (SBC). The SBC provides you information to better understand your plan and allows you to compare coverage options.

This package is required due to one of the following plan coverage events:

At Employee Enrollment/Application:

SBCs must be given to eligible enrollees; including new hires at the time written application materials for enrollment are distributed. If no written application materials are distributed for enrollment, then the SBC must be given no later than the first date on which the subscriber is eligible to enroll.

Special Enrollees:

Special enrollees must be given an SBC within 90 days of enrollment.

Confirmed Renewal:

SBC must be provided 30 days prior to the renewal date for the plan the member is currently enrolled in or the first day of open enrollment if that occurs sooner, unless the group has not provided its intent to renew by that time, in which case the SBC must be delivered within seven business days of receiving their intent to renew. If the employer makes plan changes after providing a renewal SBC, then a new SBC must be distributed by the first day of coverage.

Upon Request:

An SBC must be given to employees and their dependents within seven business days of a request for the SBC.

Mid-Year Plan Change:

If a material modification to a plan is made, an SBC must be given to employees and their dependents 60 days in advance of the start date. We will supply you with an updated SBC to share with your employees and their dependents notifying them of the material modification.

Please distribute a copy of the SBC to all employees and their dependents within the timeframes noted above. We appreciate your assistance in meeting the SBC member delivery requirement. You may provide the SBC to your employees by hard copy, or email if electronic delivery is appropriate. Please refer to your SBC Employer guide or visit the [United for Reform Resource Center \(www.uhc.com/summary\)](http://www.uhc.com/summary). These resources offer information to help you understand the events that trigger an SBC delivery to your employees and their dependents.

If you need assistance with any of the above information, please contact your Sales or Account Manager. We are here to help.

Sincerely,

A handwritten signature in blue ink that reads 'Andrew R Heim'.

Andrew R Heim
UnitedHealthcare

Insurance coverage provided by or through UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of the River Valley, Inc. or their affiliates. Administrative services provided by UnitedHealthcare Services, Inc., UnitedHealthcare Insurance Company of the River Valley, Inc. or their affiliates. Health plan coverage provided by or through UnitedHealthcare of South Carolina, Inc. and UnitedHealthcare Insurance Company of the River Valley, Inc.

 **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 www.uhcrivervalley.com or by calling **1-800-224-6602**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Participating: \$5,000 Indiv / \$10,000 Family Non-Participating: \$10,000 Indiv / \$20,000 Family Per contract year. Does not apply to copays, prescription 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.	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.
Is there an out-of-pocket limit on my expenses?	Yes, Participating: \$6,600 Indiv/ \$13,200 Family Non-Participating: \$20,000 Indiv/ \$40,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one 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?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization 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?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers , see www.uhcrivervalley.com or call 1-800-224-6602.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-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 does not 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 1-800-224-6602 or visit us at www.uhcrivervalley.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy. 1



- **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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay per visit	50% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	\$60 copay per visit	50% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	Not Covered	Not Covered	No coverage for manipulative (chiropractic) services.
	Preventive care/screening/immunization	No Charge	50% co-ins, after ded	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% co-ins, after ded	If services performed in outpatient hospital setting, deductible/co-ins may apply.
	Imaging (CT/PET scans, MRIs)	30% co-ins, after ded	50% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.uhcrivervalley.com	Tier 1 - Your Lowest-Cost Option	Retail: \$10 copay Mail-Order: \$25 copay	Retail: \$10 copay Mail-Order: \$25 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Authorization requirement or may result in a higher cost. If you use a non-Participating Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: \$35 copay Mail-Order: \$87.50 copay	Retail: \$35 copay Mail-Order: \$87.50 copay	
	Tier 3 - Your Highest-Cost Option	Retail: \$60 copay Mail-Order: \$150 copay	Retail: \$60 copay Mail-Order: \$150 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Retail: \$100 copay Mail-Order: \$250 copay	Retail: \$100 copay Mail-Order: \$250 copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-ins, after ded	50% co-ins, after ded	None
	Physician/surgeon fees	30% co-ins, after ded	50% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	\$250 copay per visit	\$250 copay per visit	None
	Emergency medical transportation	30% co-ins, after ded	30% co-ins, after ded *	*Participating Deductible Applies.
	Urgent care	\$60 copay per visit	50% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-participating or benefit will be reduced 10% but not more than \$1,000.
	Physician/surgeon fees	30% co-ins, after ded	50% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	\$60 copay per visit	50% co-ins, after ded	Outpatient Facility services - 30% co-ins, after ded. Pre-Authorization required for certain non-participating services or benefit will be reduced 10% but not more than \$1,000.
	Mental/Behavioral health inpatient services	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-participating or benefit will be reduced 10% but not more than \$1,000.
	Substance use disorder outpatient services	\$60 copay per visit	50% co-ins, after ded	Outpatient Facility services - 30% co-ins, after ded. Pre-Authorization required for certain non-participating services or benefit will be reduced 10% but not more than \$1,000.
	Substance use disorder inpatient services	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-participating or benefit will be reduced 10% but not more than \$1,000.
If you are pregnant	Prenatal and postnatal care	30% co-ins, after ded	50% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Participating routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	30% co-ins, after ded	50% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	30% co-ins, after ded	Not Covered	Not covered with a non-participating provider.
	Rehabilitation services	\$30 copay per outpatient visit	50% co-ins, after ded	Any combination of outpatient rehabilitation services is limited to 60 visits per policy period.
	Habilitative services	\$30 copay per outpatient visit	50% co-ins, after ded	Services provided under and limits are combined with Rehabilitation services above.
	Skilled nursing care	30% co-ins, after ded	50% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-participating or benefit will be reduced 10% but not more than \$1,000.
	Durable medical equipment	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-participating or benefit will be reduced 10% but not more than \$1,000.
	Hospice service	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-participating or benefit will be reduced 10% but not more than \$1,000.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No Coverage for Eye exam.
	Glasses	Not Covered	Not Covered	No Coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No Coverage for Dental check-up.

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 excluded services.)

- Acupuncture
- Glasses
- Routine eye care (Adult/Child)
- Bariatric surgery
- Infertility treatment
- Routine foot care
- Chiropractic care
- Long-term care
- Weight loss programs
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Dental care (Adult/Child)
- Private-duty nursing

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Hearing aids

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 1-866-747-1019. 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 visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the South Carolina Department of Insurance at 1-800-768-3467 or visit www.doi.sc.gov. Additionally, a consumer assistance program can help you file your appeal. Contact South Carolina Department of Insurance, Consumer and Individual Licensing Services at 1-800-768-3467 or visit www.doi.sc.gov.

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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.

Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.

若需要中文协助，请拨打本文件内的客户服务电话。

Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$2,120**
- **Patient pays \$5,420**

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	\$5,000
Copays	\$20
Coinsurance	\$200
Limits or exclusions	\$200
Total	\$5,420

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$3,860**
- **Patient pays \$1,540**

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	\$200
Copays	\$1,300
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$1,540

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

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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