



### What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

### What are the benefits of the UnitedHealthcare Charter Plan?

#### Get a plan with a Primary Care Provider (PCP) to help coordinate your care.

This is a health plan that requires you to select a PCP who can help guide you through the health care system so you can get the right care at the right time.

- > **Select your personal PCP from the plan network.** Each enrolled person must select a PCP. Your PCP must be in an area where you (the subscriber) lives. Your PCP will be your first point of contact when you need care.
- > **You need to get online referrals from your PCP to see a network specialist.**
- > **There's no coverage if you go out of network or if you see a network specialist without a referral.** You will be responsible for the entire cost of the service.
- > **Preventive care is covered 100% in our network.**

#### Are you a member?

Easily manage your benefits online at [myuhc.com](http://myuhc.com)® and on the go with the **UnitedHealthcare Health4Me**® mobile app.

For questions, call the member phone number on your health plan ID card.

**Not enrolled yet?** Learn more about this plan and search for network doctors or hospitals at [welcometouhc.com/charter](http://welcometouhc.com/charter) or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

### Benefits At-A-Glance

#### What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment	Individual Deductible	Co-insurance
(Your cost for an office visit)	(Your cost before the plan starts to pay)	(Your cost share after the deductible)
You have no co-payment.	\$5,000	20%

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

## Your Costs

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In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

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### Your cost if you use Network Benefits

#### Annual Deductible

##### What is an annual deductible?

The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.

- > Your co-pays don't count towards meeting the deductible unless otherwise described within the specific covered health care service.
- > All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.
- > This benefit plan includes a per occurrence deductible that applies to certain covered health care services. This per occurrence deductible must be met prior to and in addition to the medical deductible.

Medical Deductible - Individual                      \$5,000 per year

Medical Deductible - Family                         \$10,000 per year

#### Out-of-Pocket Limit

##### What is an out-of-pocket limit?

The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.

- > All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.
- > Your co-pays, co-insurance, deductibles and per occurrence deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

Out-of-Pocket Limit - Individual                      \$6,500 per year

Out-of-Pocket Limit - Family                         \$13,000 per year

## Your Costs

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### **What is a co-payment?**

A Co-payment is the amount you pay (calculated as a set dollar amount or percentage) each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, \$50 or 20%). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

### **What is Prior Authorization?**

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization.

### **Want more information?**

Find additional definitions in the glossary at [justplainclear.com](http://justplainclear.com).

## Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

### Covered Health Care Services

### Your cost if you use Network Benefits

#### Ambulance Services

Emergency Ambulance:	20% co-insurance, after the medical deductible has been met.
Non-Emergency Ambulance:	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.

#### Amino Acid-Based Elemental Formulas

20% co-insurance, after the medical deductible has been met or as stated under the Outpatient Prescription Drug Schedule of Benefits.

#### Cellular and Gene Therapy

Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided.  Prior Authorization is required.
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#### Clinical Trials

The amount you pay is based on where the covered health care service is provided.  
Prior Authorization is required.

#### Congenital Heart Disease (CHD) Surgeries

20% co-insurance, after the medical deductible has been met for services provided with a referral to the admitting Network Specialist or other Network Physician from your Primary Care Physician.

#### Dental Services - Accident Only

20% co-insurance, after the medical deductible has been met.

#### Dental Services - Anesthesia and Facility

The amount you pay is based on where the covered health care service is provided.  
Prior Authorization is required for certain services.

#### Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.
Diabetes Self-Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Outpatient Prescription Drug Rider.

## Your Costs

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### Covered Health Care Services

### Your cost if you use Network Benefits

#### Durable Medical Equipment (DME), Orthotics and Supplies

Limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.

20% co-insurance, after the medical deductible has been met.

#### Emergency Health Care Services - Outpatient

After you pay the \$250 per occurrence deductible per visit; you pay 20% co-insurance, after the medical deductible has been met.

Notification is required if confined in an Out-of-Network Hospital.

#### Examination and Treatment for Sexual Assault

You pay nothing. A deductible does not apply.

#### Gender Dysphoria

The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Rider.

Prior Authorization is required for certain services.

## Your Costs

### Covered Health Care Services

### Your cost if you use Network Benefits

#### Habilitative Services

Inpatient:

Inpatient services for adults 19 years of age and older are limited per year as follows:

Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services. For Dependents under 19 years of age, no limits apply.

The amount you pay is based on where the covered health care service is provided.

Outpatient:

Outpatient therapies:

Manipulative Treatment.

Post-cochlear implant aural therapy.

Cognitive therapy.

For the above outpatient therapies:

Limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.

20% co-insurance, after the medical deductible has been met for manipulative treatment services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician.

20% co-insurance, after the medical deductible has been met for all other habilitative services.

Visit limits for Treatment for Autism Spectrum Disorders for Enrolled Dependents under 21 years of age do not apply.

#### Hearing Aids

Limited to one hearing instrument per impaired ear every 36 months. Benefits include repairs and/or replacement of a hearing instrument when Medically Necessary.

20% co-insurance, after the medical deductible has been met.

#### Home Health Care

Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

For the administration of intravenous infusion, you must receive services from a provider we identify.

20% co-insurance, after the medical deductible has been met.

## Your Costs

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### Covered Health Care Services

### Your cost if you use Network Benefits

#### Hospice Care

20% co-insurance, after the medical deductible has been met.

#### Hospital - Inpatient Stay

20% co-insurance, after the medical deductible has been met for services provided with a referral to the admitting Network Specialist or other Network Physician from your Primary Care Physician.

#### Infertility Services

Benefits for Assisted Reproductive Technology (ART) are limited to four oocyte retrievals per plan year; however, if a retrieval is followed by a live birth, two additional oocyte retrievals will be covered. Following the final oocyte retrieval, Benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to the Covered Person.

20% co-insurance, after the medical deductible has been met for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician or when services are provided by an obstetrician or gynecologist.

Prior Authorization is required.

#### Lab, X-Ray and Diagnostic - Outpatient

Lab Testing - Outpatient:

20% co-insurance, after the medical deductible has been met.

Limited to 18 Presumptive Drug Tests per year.

Limited to 18 Definitive Drug Tests per year.

X-Ray and Other Diagnostic Testing - Outpatient:

20% co-insurance, after the medical deductible has been met.

#### Major Diagnostic and Imaging - Outpatient

20% co-insurance, after the medical deductible has been met.

#### Mental Health Care and Substance Use Disorders Services

Inpatient:

20% co-insurance, after the medical deductible has been met.

Outpatient:

You pay nothing. A deductible does not apply.

Partial Hospitalization/Intensive Outpatient Treatment:

20% co-insurance, after the medical deductible has been met.

## Your Costs

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### Covered Health Care Services

### Your cost if you use Network Benefits

#### Ostomy Supplies

Limited to \$2,500 per year.

20% co-insurance, after the medical deductible has been met.

#### Pharmaceutical Products - Outpatient

This includes medications given at a doctor's office, or in a Covered Person's home.

20% co-insurance, after the medical deductible has been met.

#### Physician Fees for Surgical and Medical Services

20% co-insurance, after the medical deductible has been met for services provided by your Primary Care Physician, Network obstetrician or gynecologist.

20% co-insurance, after the medical deductible has been met for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician.

#### Physician's Office Services - Sickness and Injury

You pay nothing for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply.

\$50 co-pay per visit for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician. A deductible does not apply.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.

#### Pregnancy - Maternity Services

The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

#### Prescription Drug Benefits

Prescription drug benefits are shown in the Prescription Drug benefit summary.

#### Preventive Care Services

Physician Office Services, Lab, X-Ray or other preventive tests.

You pay nothing for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply.

You pay nothing for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician. A deductible does not apply.

Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.



## Your Costs

### Covered Health Care Services

### Your cost if you use Network Benefits

#### Prosthetic Devices

Limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.

20% co-insurance, after the medical deductible has been met.

#### Reconstructive Procedures

The amount you pay is based on where the covered health care service is provided.

#### Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Limited to:

60 visits of pulmonary rehabilitation therapy.

60 visits of cardiac rehabilitation therapy.

60 visits of physical therapy for multiple sclerosis.

60 visits for any combination of physical therapy, occupational therapy and speech therapy.

60 visits of post-cochlear implant aural therapy.

60 visits of cognitive rehabilitation therapy.

20% co-insurance, after the medical deductible has been met for manipulative treatment services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician.

20% co-insurance, after the medical deductible has been met for all other rehabilitation services.

#### Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.

20% co-insurance, after the medical deductible has been met for services provided by your Primary Care Physician, Network obstetrician or gynecologist.

20% co-insurance, after the medical deductible has been met for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Physician.

#### Skilled Nursing Facility / Inpatient Rehabilitation Facility Services

Limited to 60 days per year.

20% co-insurance, after the medical deductible has been met.

## Your Costs

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### Covered Health Care Services

### Your cost if you use Network Benefits

#### Surgery - Outpatient

20% co-insurance, after the medical deductible has been met for services provided by your Primary Care Physician, Network obstetrician or gynecologist.

20% co-insurance, after the medical deductible has been met for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Physician.

#### Temporomandibular Joint (TMJ) and Craniomandibular Disorder (CMD) Services

The amount you pay is based on where the covered health care service is provided.

#### Therapeutic Treatments - Outpatient

Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.

20% co-insurance, after the medical deductible has been met.

#### Transplantation Services

Network Benefits must be received from a Designated Provider.

The amount you pay is based on where the covered health care service is provided.

Prior Authorization is required.

#### Urgent Care Center Services

\$75 co-pay per visit. A deductible does not apply.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.

#### Virtual Visits

Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at [myuhc.com](http://myuhc.com)<sup>®</sup> or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.

You pay nothing. A deductible does not apply.

**Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.**

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- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult/Child)
- Routine Foot Care
- Weight Loss Programs

**For Internal Use only:**

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UnitedHealthcare of Illinois, Inc. 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.

Online: [UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

Mail: Civil Rights Coordinator. United HealthCare 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 phone number listed on your ID card, 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 others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, 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 the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LUU 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 ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

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 sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniłmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises 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。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन 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 deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) ស្រវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានស្តាប់អ្នក។ សមនូវសព្វទៅលើខតតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍI BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánití'go, saad bee áka'anida'awo'ígíí, t'áá jíik'eh, bee ná'ahóot'i'. T'áá shqoqí ninaaltsoos nit'ízi bee nééhozinígíí bine'déé' t'áá jíik'ehgo béesh bee hane'í biká'ígíí bee hodíilnii.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.