



# Employee Enrollment Form

To speed the enrollment process, please be thorough and fill out all sections that apply.

<b>To Be Completed by Employer</b>		<b>Requested Effective Date of Coverage/Date of Change</b> / /		
Group Name <b>Asseff Enterprises, LLC</b>		Policy Number <b>001X3747</b>		
Date of Hire / /	Reason for Application <input type="checkbox"/> New Group Plan <input type="checkbox"/> New Hire <input type="checkbox"/> Life Event/Date _____ <input type="checkbox"/> Annual <input type="checkbox"/> Status Change _____ <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Dependent Add/Delete <input type="checkbox"/> Late <input type="checkbox"/> Change Name/Address <input type="checkbox"/> Part time to Full time Enrollee <input type="checkbox"/> Waiving Coverage <input type="checkbox"/> Termination <input type="checkbox"/> Other _____	Employee Type (Check all that apply) <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation Start dt ____/____/____ End dt ____/____/____ <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired <input type="checkbox"/> Other _____		
Position/Title		Hours Worked per week	Salary \$ _____ Required only if Life, STD, or LTD Plan based on salary	

<b>A. Employee Information</b>	<b>If you are waiving all coverage, please complete sections A and F.</b>
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Last Name		First Name		MI	Social Security Number			
Address		Apt #	City	State	Zip Code	Home/Cell Phone		
Date of Birth / /		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Email Address			Work Phone		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Language Preference, if not English		Primary Care Physician <sup>2</sup> Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Dentist <sup>3</sup>				
Physician First & Last Name _____		Dentist First & Last Name _____		ID# _____				
Address _____		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		ID# _____				

<b>B. Family Information</b>	<b>List All Enrolling (Attach sheet if necessary)</b>
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Relationship <sup>4</sup>	Last Name	First Name		MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		
Spouse	Social Security Number		Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Primary Care Physician <sup>2</sup> Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Dentist <sup>3</sup>						
Physician First & Last Name _____		Dentist First & Last Name _____						
Address _____		ID# _____						
ID# _____		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No						

(1) Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. (2) For UnitedHealthcare Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. (3) Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. (4) For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible employee, please provide address on a separate sheet. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

Coverage Provided by "UnitedHealthcare and Affiliates":  
 Medical coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of the Midwest, Inc.  
 Dental coverage provided by UnitedHealthcare Insurance Company  
 Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company  
 Vision coverage provided by UnitedHealthcare Insurance Company

Employee Name \_\_\_\_\_

**B. Family/Dependent Information (continued) List All Enrolling (Attach sheet if necessary)**

Relationship <sup>4</sup>	Last Name _____	First Name _____	MI _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Dependent	Social Security Number       -	Do you use tobacco? <sup>1</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Primary Care Physician<sup>2</sup></b> Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID#                             -	<b>Primary Care Dentist<sup>3</sup></b> Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist First & Last Name _____ ID# _____ Permanently disabled and age 26 or older <sup>5</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No
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Relationship <sup>4</sup>	Last Name _____	First Name _____	MI _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Dependent	Social Security Number       -	Do you use tobacco? <sup>1</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Primary Care Physician<sup>2</sup></b> Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID#                             -	<b>Primary Care Dentist<sup>3</sup></b> Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist First & Last Name _____ ID# _____ Permanently disabled and age 26 or older <sup>5</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No
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Relationship <sup>4</sup>	Last Name _____	First Name _____	MI _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Dependent	Social Security Number       -	Do you use tobacco? <sup>1</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Primary Care Physician<sup>2</sup></b> Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID#                             -	<b>Primary Care Dentist<sup>3</sup></b> Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist First & Last Name _____ ID# _____ Permanently disabled and age 26 or older <sup>5</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No
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Relationship <sup>4</sup>	Last Name _____	First Name _____	MI _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
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Dependent	Social Security Number       -	Do you use tobacco? <sup>1</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Primary Care Physician<sup>2</sup></b> Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician First & Last Name _____ Address _____ ID#                             -	<b>Primary Care Dentist<sup>3</sup></b> Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist First & Last Name _____ ID# _____ Permanently disabled and age 26 or older <sup>5</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No
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**C. Product Selection** Please check the box for each coverage in which you or your dependents are enrolling. If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Basic Life/AD&D	Supp Life/AD&D	STD	LTD
Employee	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Spouse	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Dependent	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/>	<input type="checkbox"/>

**This health benefit plan does not include coverage for elective abortions.**

**Exclusive Provider Organization Notice**  
 This notice applies to managed care health benefit plans that require all health care services be delivered by providers participating in our network. With the exception of emergency medical conditions, life-threatening conditions, disabling degenerative disease treatments, and certain mental health benefits, this health benefit plan covers only services received by providers participating in our network.  
 You can opt-out of this health benefit plan and be enrolled in a health benefit plan which includes out-of-network benefits by checking the box on the right.

Employee Name \_\_\_\_\_

**C. Product Selection (continued)**

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)	Relationship
Primary	
Secondary	

**D. Prior Medical Insurance Information**

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?

NO  YES (if yes, please complete this section.)

Prior medical carrier name \_\_\_\_\_ Effective date \_\_\_\_\_ End date \_\_\_\_\_

Prior coverage type:  Employee  Spouse  Child(ren)  Family

**E. Other Medical Coverage Information This section must be completed. (Attach sheet if necessary.)**

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare?  YES (continue completing this section)  NO (skip the rest of this section)

Name of other carrier \_\_\_\_\_

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

\*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)

S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

Enrolled in Part A: Effective Date \_\_\_\_\_  Ineligible for Part A\*  Not Enrolled in Part A (chose not to enroll)\*\*

Enrolled in Part B: Effective Date \_\_\_\_\_  Ineligible for Part B\*  Not Enrolled in Part B (chose not to enroll)\*\*

Enrolled in Part D: Effective Date \_\_\_\_\_  Ineligible for Part D\*  Not Enrolled in Part D (chose not to enroll)\*\*

Reason for Medicare eligibility:  Over 65  Kidney Disease  Disabled  Disabled but actively at work

Are you receiving Social Security Disability Insurance (SSDI)?  YES  NO Start Date \_\_\_\_ \_\_ \_\_

Medicare – Spouse/Dependent Name: \_\_\_\_\_

Enrolled in Part A: Effective Date \_\_\_\_\_  Ineligible for Part A\*  Not Enrolled in Part A (chose not to enroll)\*\*

Enrolled in Part B: Effective Date \_\_\_\_\_  Ineligible for Part B\*  Not Enrolled in Part B (chose not to enroll)\*\*

Enrolled in Part D: Effective Date \_\_\_\_\_  Ineligible for Part D\*  Not Enrolled in Part D (chose not to enroll)\*\*

Reason for Medicare eligibility:  Over 65  Kidney Disease  Disabled  Disabled but actively at work

\*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

\*\* If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

**F. Waiver of Coverage**

I decline all coverage for:

- Myself
- Spouse
- Dependent Children
- Myself and all dependents

Declining coverage due to existence of other coverage:

- Spouse's Employer's Plan
- Covered by Medicare
- COBRA from Prior Employer
- Tri-Care
- I (we) have no other coverage at this time
- Other \_\_\_\_\_
- Individual Plan
- Medicaid
- VA Eligibility

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period.

Date \_\_\_\_\_ Employee Signature if waiving coverage \_\_\_\_\_

**G. Signature**

I authorize UnitedHealthcare Insurance Company and its affiliates (collectively, "UnitedHealthcare") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand that the purpose of the disclosure and use of my information is to allow UnitedHealthcare to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that UnitedHealthcare is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective.

Please maintain a copy of this authorization for your records.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)
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**H. Census Information (optional)**

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply:     White     Black, African-American     American Indian/Alaska Native     Asian  
                                                  Native Hawaiian/Pacific Islander     Other Race, please specify \_\_\_\_\_
2. Are you of Hispanic or Latino origin?     Yes     No



**!** 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 [www.welcometouhc.com](http://www.welcometouhc.com) or by calling 1-866-673-6293. 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](http://www.healthcare.gov/sbc-glossary) or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Network: \$5,000 Individual / \$10,000 Family out-of-Network: \$10,000 Individual / \$20,000 Family Per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own <u>individual deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Network: \$7,000 Individual / \$14,000 Family out-of-Network: \$20,000 Individual / \$40,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing charges</u> (unless <u>balanced billing</u> is prohibited), <u>health care</u> this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> or call 1-866-673-6293 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

**!** 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 Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	45% coinsurance	Virtual visits (Telehealth) - 20% coinsurance by a Designated Virtual Network Provider. No virtual coverage for out-of-Network. Cost share applies to any other Telehealth service based on provider type.
	Specialist visit	20% coinsurance	45% coinsurance	None
If you have a test	Preventive care/screening/immunization	No Charge	* Not Covered	*Certain services are covered when using an out-of-Network. Includes preventive health services specified in the health care reform law. 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. *Deductible/coinsurance may not apply to certain services.
	Diagnostic test (x-ray, blood work)	Designated Network Lab: 20% coinsurance X-ray: 20% coinsurance.	45% coinsurance	Preauthorization required for out-of-Network for certain services or benefit reduces to 50% of allowed. For Designated Network Benefits, lab services must be received by a Designated Diagnostic Provider. Network Benefits are lab services received from a Network provider that is not a Designated Diagnostic Provider and is covered at 45% coinsurance.
	Imaging (CT/PET scans, MRIs)	Designated Network: 20% coinsurance	45% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed. For Designated Network Benefits, radiology services must be received from a Designated Diagnostic Provider. Network Benefits are services received from a Network provider that is not a Designated Diagnostic Provider and is covered at 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)
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.welcometouhc.com">www.welcometouhc.com</a></p>	<p>Tier 1 - Your Lowest-Cost Option</p> <p>Tier 2 - Your Midrange-Cost Option</p> <p>Tier 3 - Your Midrange-Cost Option</p> <p>Tier 4 - Additional High-Cost Options</p>	<p>Retail: 50% coinsurance Mail-Order: 50% coinsurance</p> <p>Retail: 50% coinsurance Mail-Order: 50% coinsurance</p> <p>Retail: 50% coinsurance Mail-Order: 50% coinsurance</p> <p>Not Applicable</p>	<p>Retail: 50% coinsurance</p> <p>Retail: 50% coinsurance</p> <p>Retail: 50% coinsurance</p> <p>Not Applicable</p>
<p>If you have outpatient surgery</p>	<p>Facility fee (e.g., ambulatory surgery center)</p> <p>Physician/surgeon fees</p>	<p>20% coinsurance</p> <p>20% coinsurance</p>	<p>45% coinsurance</p> <p>45% coinsurance</p>
<p>If you need immediate medical attention</p>	<p>Emergency room care</p> <p>Emergency medical transportation</p> <p>Urgent care</p>	<p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p>	<p>None</p> <p>None</p> <p>None</p> <p>None</p>
<p>If you have a hospital stay</p>	<p>Facility fee (e.g., hospital room)</p>	<p>20% coinsurance</p> <p>20% coinsurance</p>	<p>45% coinsurance</p> <p>45% coinsurance</p>

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	20% coinsurance	45% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	45% coinsurance	Network partial hospitalization /intensive outpatient treatment: 20% coinsurance Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.
If you are pregnant	Inpatient services	20% coinsurance	45% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Office visits	No Charge	25% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	45% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
If you need help recovering or have other special health needs	Childbirth/delivery facility services	20% coinsurance	45% coinsurance	Inpatient preauthorization apply for out-of-Network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed.
	Home health care	20% coinsurance	45% coinsurance	Limited to 60 visits per calendar year. Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Rehabilitation services	20% coinsurance	45% coinsurance	Limits per calendar year: Physical, Speech, Occupational: 30 visits (combined). Pulmonary: 36 visits; Cardiac: 36 visits.
	Habilitation services	20% coinsurance	45% coinsurance	Services provided under and limits are combined with Rehabilitation services above. Cost share applies for outpatient services only. Preauthorization required for out-of-Network inpatient services or benefit reduces to 50% of allowed.
	Skilled nursing care	20% coinsurance	45% coinsurance	Skilled Nursing Facility is limited to 60 days per calendar year (combined with Inpatient Rehabilitation). Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.



Common Medical Event	Services You May Need	What You Will Pay	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Durable medical equipment	20% coinsurance	Not Covered	Covers 1 per type of Durable medical equipment (including repair/replace) every 3 years.
	Hospice services	20% coinsurance	45% coinsurance	Preauthorization required for out-of-Network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Eye exam.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

**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.)
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult/Child)</li> <li>Glasses</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> <li>Routine eye care (Adult/Child)</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
<ul style="list-style-type: none"> <li>Chiropractic care-20 visits per calendar year</li> <li>Hearing aids</li> <li>Infertility treatment - In Vitro Services only</li> </ul>

**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: 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) for the U.S. Department of Labor, Employee Benefits Security Administration, you may also contact us at 1-866-673-6293. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://HealthInsuranceMarketplace). For more information about the [Marketplace](http://Marketplace), visit [www.HealthCare.gov](http://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: 1-866-673-6293 ; or the Employee Benefits Security Administration at 1-866-444-EBBSA (3272) or

www.dol.gov/ebsa/healthreform or the Arkansas Insurance Department at 1-501-371-2640 or 1-800-852-5494 or www.insurance.arkansas.gov. Additionally, a consumer assistance program can help you file your appeal Contact Arkansas Insurance Department, Consumer Services Division 855-332-2227 or visit www.insurance.arkansas.gov.

**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 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 1-866-673-6293.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-673-6293.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-673-6293.

Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwijijgo holne' 1-866-673-6293.

*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 \$ 5,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,260</b>

**Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$ 5,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$5,100</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$ 5,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>



## Notice of Non-Discrimination

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)**, udostępniłmy 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 Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क 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: បើសិនអ្នកនិយាយភាសាខ្មែរ (**Khmer**) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតថ្លៃ ដែលមានកក់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ 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 yáníiti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i. T'áá shqodí 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 hodiilnih.

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).