AT&T: Mobility HCN Option 1 (Rx 45)

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.myuhc.com. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-877-722-0020 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Medical, including MH/SUD; For Indiv/Indiv+Child(ren)/Indiv+Spouse/Fam: **Network/ONA:** $700/$1,400/$1,400/$1,400; **Non-Network:** $2,450/$4,900/$4,900/$4,900	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?	Preventive care services 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.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**Medical:** Medical, including MH/SUD Includes Annual **Deductible**; For Indiv/Indiv+Child(ren)/Indiv+Spouse/Fam: **Network/ONA:** $3,500/$7,000/$7,000/$7,000; **Non-Network:** $10,500/$21,000/$21,000/$21,000; **Rx**: Indiv and Fam: $1,200/$2,400; Combined with Mail Order Rx Service; **Network Co-payments** apply; The Rx Annual Out-of-Pocket Max is separate from any medical and MH/SUD Annual Out-of-Pocket Max that may apply	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?	**Medical**: Amounts that exceed allowable charges for eligible expenses, **Balance-billed** charges, Contributions, Health care this **plan**	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**

Important Questions	Answers	Why this Matters:
	doesn't cover, Ineligible expenses, Non-Network Allowable Charges, Notice or **preauthorization** penalties, Outpatient **prescription drug** expenses, **Premiums**; **Rx**: Rxs that are not a Covered Health Service; Additional costs incurred for failure to comply with Program terms (such as mandatory Generic Drug penalty); Rxs purchased at a Non-Network Retail Pharmacy.	
Will you pay less if you use a network provider?	Yes. For a list of **network** providers, see www.myuhc.com or call 1-877-506-7221	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	Non-Network	ONA	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% **Coinsurance**	50% **Coinsurance**	10% **Coinsurance**	——————none——————
	Specialist visit	10% **Coinsurance**	50% **Coinsurance**	10% **Coinsurance**	——————none——————
	Preventive care/screening/ immunization	0% **Coinsurance**	Not covered	0% **Coinsurance**	Annual **Deductible** does not apply
If you have a test	**Diagnostic test** (x-ray, blood work)	10% **Coinsurance**	50% **Coinsurance**	10% **Coinsurance**	——————none——————
	Imaging (CT/PET scans, MRIs)	10% **Coinsurance**	50% **Coinsurance**	10% **Coinsurance**	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-800-378-8851 or www.caremark.com.	Generic drugs	Retail: $10 **Copay**/Rx; Mail Order: $20 **Copay**/Rx	You pay full cost of drug then file a claim for reimbursement; 50% covered of discounted price	Same as **Network** and Non-Network	Retail: Up to a 30-day supply, limited to two (2) fills for maintenance prescriptions then must use Mail Order; Mail Order: Up to a 90-day supply
	Preferred brand drugs	Retail: $35 **Copay**/Rx; Mail Order: $70 **Copay**/Rx	See Generic Drugs	Same as **Network** and Non-Network	Retail: Up to a 30-day supply, limited to two (2) fills for maintenance prescriptions then must use Mail Order; Mail Order: Up to a 90-day supply
	Non-preferred brand drugs	Retail: $70 **Copay**/Rx; Mail Order: $140 **Copay**/Rx	See Generic Drugs	Same as **Network** and Non-Network	Retail: Up to a 30-day supply, limited to two (2) fills for maintenance prescriptions then must use Mail Order; Mail Order: Up to a 90-day supply

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network	Non-Network	ONA	
	Specialty drugs	Covered, refer to **Copays** above	Covered, refer to **Copays** above	Same as **Network** and Non-Network	Retail: Specialty Prescription Drugs must be filled through the Prescription Drug Benefits Administrator's Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% **Coinsurance**	50% **Coinsurance**	10% **Coinsurance**	——————none——————
	Physician/surgeon fees	10% **Coinsurance**	50% **Coinsurance**	10% **Coinsurance**	——————none——————
If you need immediate medical attention	**Emergency room care**	10% **Coinsurance**	10% **Coinsurance**	10% **Coinsurance**	——————none——————
	Emergency medical transportation	10% **Coinsurance**	10% **Coinsurance**	10% **Coinsurance**	——————none——————
	Urgent care	10% **Coinsurance**	50% **Coinsurance**	10% **Coinsurance**	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% **Coinsurance**	50% **Coinsurance**	10% **Coinsurance**	——————none——————
	Physician/surgeon fee	10% **Coinsurance**	50% **Coinsurance**	10% **Coinsurance**	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	10% **Coinsurance**	50% **Coinsurance**	10% **Coinsurance**	——————none——————
	Inpatient services	10% **Coinsurance**	50% **Coinsurance**	10% **Coinsurance**	——————none——————
If you are pregnant	Office visits	10% **Coinsurance**	50% **Coinsurance**	10% **Coinsurance**	For routine prenatal care, check with Benefits Administrator
	Childbirth/delivery professional services	10% **Coinsurance**	50% **Coinsurance**	10% **Coinsurance**	——————none——————
	Childbirth/delivery facility services	10% **Coinsurance**	50% **Coinsurance**	10% **Coinsurance**	——————none——————

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network	Non-Network	ONA	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	50% Coinsurance	10% Coinsurance	Non-Network: Limited to 60 visits/yr
	Rehabilitation services	10% Coinsurance	50% Coinsurance	10% Coinsurance	——————none——————
	Habilitation services	Not covered	Not covered	Not covered	——————none——————
	Skilled nursing care	10% Coinsurance	50% Coinsurance	10% Coinsurance	Network: Limited to 100 days/calendar yr (combined Network and Non-Network Services); Non-Network: Limited to 60 days/calendar yr (combined Network and Non-Network Services); ONA: Limited to 100 days/calendar yr
	Durable medical equipment	10% Coinsurance	50% Coinsurance	10% Coinsurance	——————none——————
	Hospice services	10% Coinsurance	Not covered	10% Coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	——————none——————
	Children's glasses	Not covered	Not covered	Not covered	——————none——————
	Children's dental check-up	Not covered	Not covered	Not covered	——————none——————

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 (Except for anesthesia purposes)
- Bariatric surgery
- Cosmetic surgery
- Dental care - adult (Except for accidental injury)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult (Except for medical eye exams for diabetics)
- Routine foot care (Except for severe systemic disease)
- Weight loss programs (Unless covered by preventive care (e.g. nutritional counseling) or a wellness program specifically provided under the plan)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Hearing aids (Limited exceptions apply)	• Private-duty nursing

For additional limitations and requirements, such as visit limits and preauthorization, refer to the SPD.

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** for the U.S. Department of Labor, Employee Benefits Security Administration, or 1-877-267-2323 x61565 or **www.cciio.cms.gov** for the U.S. Department of Health and Human Services. You may also contact your state insurance department. 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 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: UnitedHealthcare 1-877-506-7221.

Does this Coverage Provide Minimum Essential Coverage? Yes.
If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? 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 1-877-722-0020.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-722-0020.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-722-0020.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-722-0020.

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

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	**$700**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$700
Copayments	$40
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,000**

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

The plan's overall deductible	**$700**
Specialist coinsurance	**10%**
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$700
Copayments	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,560**

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

The plan's overall deductible	**$700**
Specialist coinsurance	**10%**
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$40
The total Mia would pay is	**$840**

Note: These numbers assume the patient does not participate in the **plan's** wellness program. If you participate in the **plan's** wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-877-506-7221.

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

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