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.healthselectoftexas.com** or by calling **(866) 336-9371 (TTY 711)**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200** person **/** **$600** family	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?	Yes. **$50** for prescription drug expenses per person, **$5,000** for bariatric surgery for active employees, and **$200** per service for certain non-prior authorized services.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,550** person **/ $13,100** family. **$3,000** coinsurance maximum per person.	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?	Contributions, balance-billed charges, health care this plan doesn't cover, and bariatric surgery benefits.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers, see www.healthselectoftexas.com or call **(866) 336-9371**.	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, referrals are not required to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: Call **(866) 336-9371** for Customer Service or visit us at **www.healthselectoftexas.com**. If you aren't clear about any of the underlined terms used in this document, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call **(866) 336-9371** to request a copy.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	30% coinsurance	----------None----------
	Specialist visit	30% coinsurance	30% coinsurance	----------None----------
	Other practitioner office visit	Not Covered	Not Covered	----------None----------
	Preventive care/screening/immunization	No Charge	30% coinsurance	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	30% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)	$100 copay plus 30% coinsurance	$100 copay plus 30% coinsurance	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at: www.caremark.com/ers	Generic drugs	$10 copay (non-maintenance), $10 copay (maintenance); $30 copay (mail order or extended day supply)	$10 copay plus 40% coinsurance (non-maintenance) $10 copay plus 40% coinsurance (maintenance); $30 copay plus 40% coinsurance (mail order or extended day supply)	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Preferred brand drugs	$35 copay (non-maintenance), $45 copay (maintenance); $105 copay (mail order or extended day supply)	$35 copay plus 40% coinsurance (non-maintenance) $45 copay plus 40% coinsurance (maintenance); $105 copay plus 40% coinsurance (mail order or extended day supply)	Prior authorization may be required. Failure to obtain prior authorization may increase your cost. Note: If a generic drug is available and you choose to buy the preferred brand drug, you will pay the generic copay plus the cost difference between the preferred brand drug and the generic drug.
	Non-preferred brand drugs	$60 copay (non-maintenance), $75 copay (maintenance); $180 copay (mail order or extended day supply)	$60 copay plus 40% coinsurance (non-maintenance) $75 copay plus 40% coinsurance (maintenance); $180 copay plus 40% coinsurance (mail order or extended day supply)	Prior authorization may be required. Failure to obtain prior authorization may increase your cost. Note: If a generic drug is available and you choose to buy the non-preferred brand drug, you will pay the generic copay plus the cost difference between the non-preferred brand drug and the generic drug.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Specialty drugs	If purchased through a pharmacy, specialty drugs are covered as preferred brand drugs or non-preferred brand drugs as listed above. Otherwise, covered as a medical benefit.	If purchased through a pharmacy, specialty drugs are covered as preferred brand drugs or non-preferred brand drugs as listed above. Otherwise, covered as a medical benefit.	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay plus 30% coinsurance	$100 copay plus 30% coinsurance	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Physician/surgeon fees	30% coinsurance	30% coinsurance	----------None----------
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	----------None----------
	Emergency medical transportation	30% coinsurance	30% coinsurance	----------None----------
	Urgent care	30% coinsurance	30% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$150/day copay per admission plus 30% coinsurance	$150/day copay per admission plus 30% coinsurance	$750 copay max per admission. $2,250 copay max per calendar year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Physician/surgeon fee	30% coinsurance	30% coinsurance	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% coinsurance	30% coinsurance	----------None----------
	Mental/Behavioral health inpatient services	$150/day copay per admission plus 30% coinsurance	$150/day copay per admission plus 30% coinsurance	$750 copay max per admission. $2,250 copay max per calendar year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Substance use disorder outpatient services	30% coinsurance	30% coinsurance	----------None----------
	Substance use disorder inpatient services	$150/day copay per admission plus 30% coinsurance	$150/day copay per admission plus 30% coinsurance	$750 copay max per admission. $2,250 copay max per calendar year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you are pregnant	Prenatal and postnatal care	No Charge	30% coinsurance	No charge for network pre-natal visits or obstetrician delivery.
	Delivery and all inpatient services	$150/day copay per admission plus 30% coinsurance	$150/day copay per admission plus 30% coinsurance	$750 copay max per admission. $2,250 copay max per calendar year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge (no deductible) 30% coinsurance for home infusion therapy	No Charge (no deductible) 30% coinsurance for home infusion therapy	Max of 100 visits per calendar year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Rehabilitation services	30% coinsurance	30% coinsurance	----------None----------
	Habilitation services	30% coinsurance	30% coinsurance	----------None----------
	Skilled nursing care	No Charge (no deductible)	No Charge (no deductible)	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Durable medical equipment	30% coinsurance	30% coinsurance	Replacement limit of one every 3 years per person unless change in condition or physical status. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Hospice service	30% coinsurance (no deductible)	30% coinsurance (no deductible)	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If your child needs dental or eye care	Eye exam	30% coinsurance	30% coinsurance	Limit of one routine exam per calendar year per person.
	Glasses	Not Covered	Not Covered	----------None----------
	Dental check-up	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
- Artificial insemination
- Cosmetic surgery
- Dental check-up
- Educational services, excluding Diabetes Self-Management Training Programs.
- Glasses
- Long-term care
- Personal comfort items
- Routine foot care
- Weight-loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye exams
- Virtual Visits

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**[1], 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 (866) 336-9371. 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 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 (866) 336-9371 or visit www.healthselectoftexas.com.

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 (866) 336-9371 durante el horario de 8:00am a 7:00pm CST Lunes-Viernes, y 7:00am a 3:00pm CST Sábado.

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

[1] Under the HealthSelect plan, the payment you make for health plan coverage is called a contribution rather than a premium.

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** $5,430
- **Patient pays** $2,110

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 (Prescription + $200 annual)	$250
Copays (3 day hospital inpatient stay)	$450
Coinsurance	$1,410
Limits or exclusions	$0
Total	**$2,110**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your cost may be higher. For more information, please contact (866)336-9371.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,220
- **Patient pays** $1,180

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 (Prescription + $200 annual)	$250
Copays (6 months of preferred brand name insulin)	$270
Coinsurance	$660
Limits or exclusions	$0
Total	**$1,180**

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.

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.

Questions: Call **(866) 336-9371** for Customer Service or visit us at **www.healthselectoftexas.com**. If you aren't clear about any of the underlined terms used in this document, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call **(866) 336-9371** to request a copy.

UnitedHealthcare Services, Inc., on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UnitedHealthcare provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call toll-free 866-336-9371, TTY 711, Monday through Friday, 8 a.m. to 7 p.m. CT and Saturday, 7 a.m. to 3 p.m. CT.

If you believe that the Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Civil Rights Coordinator
P.O. Box 30608
Salt Lake City, UT 84130
UHC_Civil_Rights@UHC.com

If you need help filing a grievance, please call toll-free 866-336-9371, TTY 711, Monday through Friday, 8 a.m. to 7 p.m. CT and Saturday, 7 a.m. to 3 p.m. CT.
Your can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:
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 1-800-868-1019, 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

You have the right to get help and information in your language at no cost. To request an interpreter, please call toll-free 866-336-9371, TTY 711, Monday through Friday, 8 a.m. to 7 p.m. CT and Saturday, 7 a.m. to 3 p.m. CT.

This letter is also available in other formats like large print. To request the document in another format, please call toll-free 866-336-9371, TTY 711, Monday through Friday, 8 a.m. to 7 p.m. CT and Saturday, 7 a.m. to 3 p.m. CT.

1	Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 866-336-9371 TTY 711
2	Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 866-336-9371 TTY 711
3	Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 866-336-9371。聽力語言殘障服務專線 711
4	Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 866-336-9371 번을 누르십시오. TTY 711
5	Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على866-336-9371. الهاتف النصي (TTY) 711
6	Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 866-336-9371 دبائیں۔ TTY 711
7	Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 866-336-9371 TTY 711
8	French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d’affilié du régime de soins de santé et appuyez sur la touche 866-336-9371 ATS 711.
9	Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 866-336-9371 दबाएं। TTY 711

10	Persian	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان 866-336-9371 را فشار دهید و قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و TTY 711.
11	German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 866-336-9371 TTY 711
12	Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 866-336-9371 દબાવો. TTY 711
13	Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 866-336-9371 Линия TTY 711
14	Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、866-336-9371を押してください。TTY専用番号は 711です。
15	Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາໝາຍເລກໂທລະສັບສຳລັບ ສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 866-336-9371 TTY 711