

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services


United Healthcare : American Museum of Natural History-Richard Gilder Graduate School
2024-203213-61

Coverage Period: 09/01/2024 - 08/31/2025
Coverage for: Student/Family | Plan Type: PPO



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.uhcsr.com or call 1-844-828-5236. For general definitions of common terms, such as allowed amount, balance billing, coinsurance (coins), copayment (copay), deductible (ded), provider, or other underlined terms, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-505-4160 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Providers \$150 / (Person) Out-of-Network Provider \$500 / (Person)	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.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , Pediatric Dental, Pediatric Vision and categories that specify <u>ded</u> does not apply.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Preferred Providers \$5,000 / (Person) Preferred Providers \$10,000 / (Family) Out-of-Network Provider \$8,000 / (Person)	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.
What is not included in the out-of-pocket limit?	Premiums, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.uhcsr.com or call 1-844-828-5236 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</u> charge 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.
Do you need a referral to see a specialist?	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		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 Copay per visit ded does not apply	30% <u>Coins</u>	May not apply when related to surgery or Physiotherapy.
	<u>Specialist visit</u>	\$25 Copay per visit ded does not apply	30% <u>Coins</u>	
	<u>Preventive care/screening/immunization</u>	Covered in full	30% <u>Coins</u>	Includes <u>preventive services</u> specified in the health care reform law or benefits provided as mandated by state law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>Coins</u>	40% <u>Coins</u>	—————none—————
	<u>Imaging</u> (CT/PET scans, MRIs)	10% <u>Coins</u>	40% <u>Coins</u>	—————none—————
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.uhcsr.com/pdl	Tier 1 - Your Lowest-Cost Option	\$15 Copay per prescription Tier 1; ded does not apply	\$20 <u>Copay</u> per prescription generic drug \$75 <u>Copay</u> per prescription brand-name drug <u>ded</u> does not apply	Preferred Providers: up to a 30-day supply per prescription Preferred Providers: Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90-day supply You may need to obtain certain specialty drugs from a pharmacy designated by us. You may need to obtain prior authorization for certain prescription drugs.
	Tier 2 - Your Midrange-Cost Option	\$40 Copay per prescription Tier 2; ded does not apply	\$20 <u>Copay</u> per prescription generic drug \$75 <u>Copay</u> per prescription brand-name drug <u>ded</u> does not apply	
	Tier 3 - Your Highest-Cost Option	\$75 Copay per prescription Tier 3	\$20 Copay per prescription generic drug \$75 Copay per prescription brand-name	

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			drug <u>ded</u> does not apply	
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>Coins</u>	40% <u>Coins</u>	_____none_____
	Physician/surgeon fees	10% <u>Coins</u>	40% <u>Coins</u>	_____none_____
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>Coins</u> \$100 <u>Copay</u> <u>ded</u> does not apply	10% <u>Coins</u> \$100 <u>Copay</u> <u>ded</u> does not apply	May be limited to use of emergency room and supplies.
	<u>Emergency medical transportation</u>	10% <u>Coins</u>	10% <u>Coins</u>	_____none_____
	<u>Urgent care</u>	10% <u>Coins</u> \$50 <u>Copay</u> <u>ded</u> does not apply	40% <u>Coins</u> \$50 <u>Copay</u> <u>ded</u> does not apply	May be limited to facility fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>Coins</u>	40% <u>Coins</u>	_____none_____
	Physician/surgeon fees	10% <u>Coins</u>	40% <u>Coins</u>	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: \$25 Copay per visit <u>ded</u> does not apply Other: 10% <u>Coins</u>	Office Visits: 30% <u>Coins</u> Other: 0% <u>Coins</u>	_____none_____
	Inpatient services	10% <u>Coins</u>	40% <u>Coins</u>	_____none_____
If you are pregnant	Office visits	\$25 Copay per visit <u>ded</u> does not apply	30% <u>Coins</u>	<u>Cost-sharing</u> does not apply for <u>preventive services</u> when provided by a <u>preferred provider</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% <u>Coins</u>	40% <u>Coins</u>	
	Childbirth/delivery facility services	10% <u>Coins</u>	40% <u>Coins</u>	_____none_____
If you need help recovering or have	<u>Home health care</u>	10% <u>Coins</u>	40% <u>Coins</u>	_____none_____
	<u>Rehabilitation services</u>	10% <u>Coins</u>	40% <u>Coins</u>	Outpatient: 365 visits per Plan Year Inpatient: 365 days per Plan Year

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs	<u>Habilitation services</u>	10% <u>Coins</u>	40% <u>Coins</u>	Outpatient: 365 visits per Plan Year Inpatient: 365 days per Plan Year
	<u>Skilled nursing care</u>	10% <u>Coins</u>	40% <u>Coins</u>	365 days per Plan Year
	<u>Durable medical equipment</u>	10% <u>Coins</u>	10% <u>Coins</u>	—————none—————
	<u>Hospice services</u>	10% <u>Coins</u>	40% <u>Coins</u>	365 days per Plan Year
If your child needs dental or eye care	Children's eye exam	\$20 <u>Copay</u> per exam; <u>ded</u> does not apply	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*
	Children's glasses	Lens: \$40 <u>Copay</u> ; <u>ded</u> does not apply Frames: \$40 <u>Copay</u> ; <u>ded</u> does not apply	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*
	Children's dental check-up	Exam & Cleaning: \$35 <u>Copay</u> ; <u>ded</u> does not apply Routine Xrays: \$100 <u>Copay</u> ; <u>ded</u> does not apply	Exam & Cleaning: \$35 <u>Copay</u> ; <u>ded</u> does not apply Routine Xrays: \$100 <u>Copay</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Dental Benefit Details. Age limits apply.*

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.)

- Bariatric surgery except as specifically provided in the Policy
- Cosmetic surgery
- Dental care (Adult) except as specifically provided in the Policy
- Long-term care except as specifically provided in the Policy
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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: UnitedHealthcare Student Resources at 1-800-767-0700 and New York Department of Financial Services at 1-800-342-3736 or visit <http://www.dfs.ny.gov/index.html>. 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 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: New York Department of Financial Services at 1-800-342-3736 or visit <http://www.dfs.ny.gov/index.html>.

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? Not Applicable.

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 1-866-260-2723.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-260-2723.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-260-2723.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-260-2723.

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 <u>plan's</u> overall <u>deductible</u>	\$150
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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*)

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$150
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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*)

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$150
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$150
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$10
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$230

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$150
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$10
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$680

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$150
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$560

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

NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources 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
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the written 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 member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

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: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/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 also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

LANGUAGE ASSISTANCE PROGRAM

We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English

Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian

Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

Amharic

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Arabic

تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian

Ձեզ մատչելի են անվճար լեզվական օգնություն ծառայություններ: Խնդրում ենք զանգահարել 1-866-260-2723 համարով:

Bantu- Kirundi

Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

Bisayan- Visayan (Cebuano)

Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

Bengali- Bangla

ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

Burmese

ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့်အတွက် အခမဲ့ ရရှိနိုင်ပါသည်။ ဝက်စ်ရှပ်ပီရှ် ဖုန်း 1-866-260-2723 ကို ခေါ်ဝင်ပါ။

Cambodian- Mon-Khmer

សេវាជំនួយភាសាខ្មែរលក់កម្ពុជា ឬ ខ្មែរលក់ 1-866-260-2723។

Cherokee

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Chinese

您可以免費獲得語言援助服務。請致電 1-866-260-2723。

Choctaw

Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla ho chi apela hinla. I paya 1-866-260-2723.

Cushite- Oromo

Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

Dutch

Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

French

Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

French Creole- Haitian Creole

Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

German

Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

Greek

Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Gujarati

ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કોલ કરો.

Hawaiian

Kōkua manuahi ma kāu ‘ōlelo i loa‘a ‘ia. E kelepona i ka helu 1-866-260-2723.

Hindi

आप के लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

Hmong

Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

Ibo

Enyemaka na-ahazi asụsụ, bu n'efu, dịrị gị. Kpọọ 1-866-260-2723.

Ilocano

Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

Indonesian

Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

Italian

Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

Japanese

無料の言語支援サービスをご利用いただけます。1-866-260-2723 までお電話ください。

Karen

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Korean

언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-866-260-2723 번으로 전화하십시오.

Kru- Bassa

Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yon. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani

خزمهتێکانی یارمەتی زمانی بەخۆرایێ یۆ تۆ دابین دکرێن. تکیایە تەلەفۆن بکە یۆ ژمارە 1-866-260-2723.

Laotian

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