UnitedHealthcare

Valero Services, Inc.
$500 Ded Ret Out of Area 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.valero.amwins.com or call 1-844-634-1235. 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 or call 1-844-634-1235 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 Individual / $1,000 Family Does not apply to pharmacy drugs, and services listed below as "No Charge".	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?	Yes. Preventive Care is 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?	Yes, Preferred, Non-Preferred Brand & Specialty Prescription Drugs $100 Individual / $200 Family	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.
What is the out-of-pocket limit for this plan?	Medical- $2,500 Individual / $5,000 Family Prescription Drugs - $4,100 Individual / $8,200 Family	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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain prior authorization for services. Copays for certain Specialty prescription drugs considered non-essential health benefits under the coverage. The copays for these drugs (though manufacturer copay assistance programs may support some fills at no remaining cost to you) will not apply toward satisfying your out-of-pocket limit or any applicable deductible.	Even though you pay these expenses, they don't count toward the out-of-pocket.
Will you pay less if you use a network provider?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Virtual visit - 20% co-ins after deductible by a Designated Virtual Network Provider.
	Specialist visit	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Prior Authorization required for sleep studies or $200 penalty.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.express-scripts.com**	Generic drugs	Retail: $10 copay/prescription Retail90 & Home Delivery: $25 copay/prescription	Coverage is limited up to a 30-day supply (retail), 84-90 day supply (Retail90) and up to a 90-day supply (Home Delivery). Coverage is subject to Preferred Formulary drug list. Some prescriptions may be subject to a Maintenance Medication Retail90 program, Step Therapy Program, Prior Authorization and/or quantity limits.
	Preferred brand drugs	Retail: $30 copay/prescription Retail90 & Home Delivery: $75 copay/prescription	
	Non-preferred brand drugs	Retail: $60 copay/prescription Retail90 & Home Delivery: $150 copay/prescription	
	Specialty drugs	Generic $25 copay/prescription Non-preferred brand $150 copay/prescription	Specialty drugs covered only when obtained through Accredo Pharmacy. For more information call 1-800-922-8279. Copays for certain specialty prescription drugs considered non-essential health benefits under the coverage bypass your out-of-pocket limit. Please see "Important Questions" regarding the coverage's out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Prior Authorization required or $200 penalty applies.
	Physician/surgeon fees	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	20% coinsurance	If admitted Prior Authorization required within 48 hours or $200 penalty. No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	None
	Urgent care	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Prior Authorization required or $200 penalty.
	Physician/surgeon fees	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Prior Authorization required for certain services or $200 penalty applies. Intensive Behavioral Therapy (ABA) 80% no deductible
	Inpatient services	20% coinsurance	Prior Authorization required or $200 penalty.
If you are pregnant	Office visits	20% coinsurance	Prior Authorization required for Inpatient stays that exceed normal 48 hours for vaginal delivery or 96 hours for cesarean or $200 penalty. Routine prenatal care is covered at no charge. Depending on the type of service, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound)
	Childbirth/delivery professional services	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Limited to 70 visits per calendar year for Home Health Care. Prior Authorization required for Home Health Care for certain services) or $200 penalty applies.
	Rehabilitation services	20% coinsurance	Occupational Therapy, Physical Therapy, Speech Therapy, Cardiac and Pulmonary Rehab. Review for medical necessity is required following the 30th visit (Review starts at visit 31).
	Habilitation services	20% coinsurance	Refer to Rehabilitation services
	Skilled nursing care	20% coinsurance	Limited to 60 days per calendar year. Prior Authorization required or $200 penalty.
	Durable medical equipment	20% coinsurance	Prior Authorization required for DME over $1,000 or $200 penalty.
	Hospice services	20% coinsurance	Prior Authorization required before admission for an inpatient stay in a hospice facility or $200 penalty.
If your child needs dental or eye care	Children's eye exam	Not covered	None
	Children's glasses	Not covered	None
	Children's dental check-up	Not covered	None

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.)

- Adult routine vision exam (i.e. refraction)
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing aids (Adult)
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric Surgery • Chiropractic care	• Hearing aids (Pediatric) • Infertility treatment	• Non-emergency care when traveling outside the U.S. • Private-duty nursing

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. 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: 1-844-634-1235 or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.
Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/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 the 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 1-844-634-1235.
Traditional Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-634-1235.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-634-1235.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-844-634-1235 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-634-1235.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-844-634-1235.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-844-634-1235.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-844-634-1235.

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**	**$500**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	**$500**
■ **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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$500**
■ **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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.