## Important Questions | Answers | Why This Matters:

### What is the overall deductible?
Ohio State Network Providers / UHC Options Providers outside Franklin Co: $150 (Person), $350 (Family) UHC Options Providers inside Franklin Co: $500 (Person), $1,500 (Family) Out of Network: $500 (Person), $1,500 (Family)

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, Pediatric Dental, Pediatric Vision and Prescription Drugs 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?
Yes. Pediatric Dental $500. There are no other specific deductibles.

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?
Ohio State Network Providers / UHC Options Providers outside Franklin Co: $2,700 (Person), $5,400 (Family) UHC Options Providers inside Franklin Co: $6,000 (Person), $12,000 (Family) Out of Network: $6,000 (Person), $12,000 (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.

### What is not included in the out-of-pocket limit?
Premiums, balance-billing charges, and health care this plan doesn’t cover.

Even though you pay these expenses, they don’t count toward the out-of-pocket limit.

### Will you pay less if you use a network provider?
Yes. See www.uhcsr.com/osu or call (844) 206-0374 for a list of network providers.

This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). 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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Preferred Provider (You will pay the least): $20 Copay per visit; ded does not apply</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Preferred Provider (You will pay the least): $20 Copay per visit; ded does not apply</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>HealthSmart RX</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Generic drugs</td>
<td>10% Coins ded does not apply</td>
<td>10% Coins ded does not apply</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>20% Coins ded does not apply</td>
<td>20% Coins ded does not apply</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>50% Coins ded does not apply</td>
<td>50% Coins ded does not apply</td>
</tr>
</tbody>
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*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/osu*
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<td></td>
<td>Preferred Provider (You will pay the least)</td>
<td>In-Network Provider</td>
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<tr>
<td></td>
<td></td>
<td>Preferred Provider (You will pay the least)</td>
<td>In-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Same as above; ded does not apply</td>
<td>Same as above; ded does not apply</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td></td>
<td>Same as above; ded does not apply</td>
<td>Same as above; ded does not apply</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 Copay per visit; ded does not apply</td>
<td>40% Coins</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Based on setting where service is performed</td>
<td>Based on setting where service is performed</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Based on setting where service is performed</td>
<td>Based on setting where service is performed</td>
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<td></td>
<td></td>
<td>Preferred Provider (You will pay the least)</td>
<td>In-Network Provider</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Based on setting where service is performed</td>
<td>Based on setting where service is performed</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Based on setting where service is performed</td>
<td>Based on setting where service is performed</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>Based on setting where service is performed</td>
<td>Based on setting where service is performed</td>
</tr>
<tr>
<td></td>
<td>...</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>See your plan's Pediatric Vision Benefit Details</td>
<td>50% Coins; ded does not apply</td>
</tr>
</tbody>
</table>

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<td></td>
<td></td>
<td>Preferred Provider (You will pay the least)</td>
<td>In-Network Provider</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>See your plan’s Pediatric Vision Benefit Details</td>
<td>50% Coins; ded does not apply</td>
<td>50% Coins; ded does not apply</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>See your plan’s Pediatric Dental Benefit Details</td>
<td>50% Coins</td>
<td>50% Coins</td>
</tr>
</tbody>
</table>
### 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
- Hearing aids
- Routine foot care
- Cosmetic surgery not specifically provided in the policy.
- Infertility treatment
- Weight loss programs
- Dental care (Adult), not specifically provided for in the policy.
- Long-term care
- Dental care (Adult), not specifically provided for in the policy.
- Weight loss programs

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

- Acupuncture
- Private-duty nursing
- Chiropractic care
- Routine eye care (Adult)
- Non-emergency care when traveling outside the U.S.

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**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: Ohio Department of Insurance at 1-800-686-1526 or visit [http://www.insurance.ohio.gov/Pages/default.aspx](http://www.insurance.ohio.gov/Pages/default.aspx). 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](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 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: Ohio Department of Insurance at 1-800-686-1526 or visit [http://www.insurance.ohio.gov/Pages/default.aspx](http://www.insurance.ohio.gov/Pages/default.aspx).

**Does this plan 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 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.

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*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/osu*
Language Access Services:


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

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

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

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

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 | $7,400 | $1,900 |

In this example, Peg would pay:

| Cost Sharing | Deductibles | $150 |
| Copayments | $40 |
| Coinsurance | $1,300 |

What isn’t covered:
- Limits or exclusions | $60 |

The total Peg would pay is | $1,550 |

In this example, Joe would pay:

| Cost Sharing | Deductibles | $150 |
| Copayments | $200 |
| Coinsurance | $200 |

What isn’t covered:
- Limits or exclusions | $60 |

The total Joe would pay is | $610 |

In this example, Mia would pay:

| Cost Sharing | Deductibles | $150 |
| Copayments | $140 |
| Coinsurance | $100 |

What isn’t covered:
- Limits or exclusions | $0 |

The total Mia would pay is | $390 |

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


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

Amharic

Arabic
توفر لك خدمات المساعدة اللازمة مجاناً. اتصل على الرقم 1-866-260-2723.

Armenian
Հերթական ծառայություններ կարելի է ստանում ժամանակավորորեն. կարող եք հաղորդել 1-866-260-2723.

Bantu-Kirundi
Uronswa ka bantu servisivy zifasitry ku nurimi zo kugufasha. Utzeroza guhamanga 1-866-260-2723.

Bisayan-Visayan(Cebuano)
Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga wala lay basad. Palihiw tawag sa 1-866-260-2723.

Bengali-Bangla
ঘরের ভাষায় সহায়তা পান জন্য নিন্মের সংখ্যার মাধ্যমে। এটি 1-866-260-2723 থেকে কল করুন।

Burmese
သင်္ချုပ်မှုများကို အားလုံးချင်သော ဘာသာဖြင့် ရယူနိုင်ပါသည်။ ထို့အတွက် 1-866-260-2723 ကို ဖော်ပြသော ကျန်ရှိပါသည်။

Cambodian-Mon-Khmer
មានសERVICE​ ដែលអាចប្រឈមប្រាក់មួយសលេខដ្ឋានបាន។ អ្នកអាចទូរស័ព្ទ 1-866-260-2723 ។

Cherokee
"Osiyo, ວõngõ, ᵇëgëh, ᵇëgëh, h₇eOT h₇eRBgO, h₇eEGGhO, D₇AGT. ᵇOgO DH æO₂Ww₇h 1-866-260-2723.

Chinese
您可以免費獲得語言援助服務，請致電 1-866-260-2723。

Chocotaw
Chaha arumpa ish arumpuli hokmvt tolsholi yvt peh pilla ho chi apela hina. 1 paya 1-866-260-2723.

Cushite-Oromo
Tajagyillwvan gargaarsa afanam kanfaltii malee siif jira. Maaloo bara lakkoosha bibilaa 1-866-260-2723 bibiilo.

Dutch
Taalbijstandsdiensten zijn gratis voor u beschikbaar. Geleeve 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

German

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

Gujarati
ભાષા સહાય સેવાઃ તમારા માટે નિશ્ચિત સુખદસ્થ છે. કૂલ કરીએ 1-866-260-2723 પર કેલ કરો.

Hawaiian
Kūkua marauahi ma kaʻō `ōlelo i loaʻa `ia. E kelepona i ka helu 1-866-260-2723.

Hindi
आप के लिए भाषा सहायता सेवाएं निश्चित उपलब्ध हैं। आप 1-866-260-2723 पर कॉल करें।

Hmong
Muaj cew joo pab txhais lus pub dawb rau koj. Thov hau rau 1-866-260-2723.

Ibo

Ilocano
Adda avan bayadana a serbisio para iti language assistance. Pangnagamit na tawagam ti 1-866-260-2723.

Indonesian

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
လက်ညာစာကြောင်းမှာ သာစည်းချိန်းထားပါသည်။ ထို့အတွက် 1-866-260-2723 ကို ဖော်ပြသော ကျန်ရှိပါသည်။

Korean
언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

Kru-Bassa
Bot ba hola ni kobol mahop nguawoog wogwi wo ba ye ha i nyuoy. Sebel i nisngi ini 1-866-260-2723.

Kurdish Sorani
ئەستەکارییەکی پێرەسیزی زمانی یەکەیە بە ژیکەکەوەی دەکرێن. کەکەکەی دەکەیەوە پەیکەر زەوەی 1-866-260-2723.

Laotian
M]}ząentk ວzą�(moveb) ເ三位 sleeVal (aw) ຕROM ເ三位 sleeVal 1-866-260-2723.
Sudanic- Fulfude

Swahili
Hudama za maada wapi lugha zinapatikana kwa ajili yako bure. Tafadhali piga simu 1-866-260-2723.

Syriaic- Assyrian

Tagalog
Ang mga serbisyo ng tulungan sa wika ay available para sa iyo ng walang bayad. Mangyaring tumawag sa 1-866-260-2723.

Telugu

Thai
ยินดีค่ะ ท่านสามารถติดต่อเราได้โดยทุกครั้งที่ต้องการaczua.

Turkish
Dil yardımı hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen 1-866-260-2723 numaranı arayınız.

Ukrainian
Пошути переведо вами безкоштовно. Дзвоніть за номером 1-866-260-2723.

Urdu
زبان کر کہ وہ معاونی خدمات آپ کیلئے اپنے سامان دیتا ہے.

Vietnamese
Dịch vụ hỗ trợ ngôn ngữ, miễn phí, dành cho quý vị. Xin vui lòng gọi 1-866-260-2723.

Yiddish

Yoruba
Isi ranlowo ede ti o je ofe, wa fun o. Pe 1-866-260-2723.