UnitedHealthcare

# the HSA (Partnership in Health) Plan

**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, go to Clorox Health & Welfare Service Center via single sign-on at Clxhub > U.S. Total Rewards > Health & Welfare Service Center > Menu > Items to Explore > Benefit Plan Materials, or directly at cloroxbenefits.com or by calling 1-833-550-5600. 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-877-468-1028 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network*: $1,600 Individual / $3,200 Family<br><br>Non-Network*: $1,600 Individual / $3,200 Family per calendar year.<br><br>*Deductibles cross-apply | 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 policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive Care 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, there are no other deductibles. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **What is the out-of-pocket limit for this plan?** | For network provider*: $2,750 Individual / $5,500 Family<br><br>For out-of-network providers*: $5,500 Individual / $11,000 Family per calendar year<br><br>*Out-of-pockets cross-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, the overall family out-of-pocket limits must be 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 pre-notification for services. | 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?** | Yes. See www.myuhc.com or call 1-877-468-1028 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.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network 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 | 20% coinsurance after deductible | 40% coinsurance after deductible | Virtual visit - In network 20% coinsurance after deductible by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply. No virtual visit coverage for out of network. |
| | Specialist visit | 20% coinsurance after deductible | 40% coinsurance after deductible | None |
| | Preventive care/screening/ immunization | No charge | 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 after deductible | 40% coinsurance after deductible | Prior authorization required out-of-network for Sleep Studies. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | 40% coinsurance after deductible | None |
| **Prescription drug coverage is carved out to OptumRx.**<br><br>**If you need drugs to treat your illness or condition more information about prescription drug coverage is available at www.myuhc.com**<br><br>**To view drug prescription drug lists go to www.whyuhc.com/clorox**<br><br>**Network Preventive Drug Copays:**<br>**30 days - $5**<br>**31-60 days - $10**<br>**61-90 days - $15** | Generic Drugs (Tier 1) | Retail: 20% coinsurance after deductible<br>Mail Order: 20% coinsurance after deductible | Retail: 40% coinsurance after deductible | Prescription drug costs are subject to the annual deductible. Certain drugs may have a Prior Authorization requirement. Coverage is limited up to a 90-day supply (Retail & Mail Order). All paper claims In/Out Network will be reimbursed at the contracted rate minus copay/coinsurance. |
| | Preferred brand drugs (Tier 2) | Retail: 20% coinsurance after deductible<br>Mail Order: 20% coinsurance after deductible | Retail: 40% coinsurance after deductible | Prescription drug costs are subject to the annual deductible. Certain drugs may have a Prior Authorization requirement. Coverage is limited up to a 90-day supply (Retail & Mail Order). All paper claims In/Out Network will be reimbursed at the contracted rate minus copay/coinsurance. |
| | Non-preferred brand drugs (Tier 3) | Retail: 20% coinsurance after deductible<br>Mail Order: 20% coinsurance after deductible | Retail: 40% coinsurance after deductible | Prescription drug costs are subject to the annual deductible. Certain drugs may have a Prior Authorization requirement. Coverage is limited up to a 90-day supply (Retail & Mail Order). All paper claims In/Out Network will be reimbursed at the contracted rate minus copay/coinsurance. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Specialty drugs (Tier 4) | Retail: N/A<br>Mail Order: N/A | Retail: N/A | Specialty Drugs are paid under Tier 2 or Tier 3. Some Specialty Drugs that require administration in a medical office will be available under the medical portion of this plan, and are not dispensed at a Retail Pharmacy as shown here. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | 40% coinsurance after deductible | Prior Authorization required out-of-network for sleep apnea surgery. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 40% coinsurance after deductible | None |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance after deductible | 20% coinsurance after deductible | None |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | None |
| | Urgent care | 20% coinsurance after deductible | 40% coinsurance after deductible | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | 40% coinsurance after deductible | Prior Authorization required out-of-network. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 40% coinsurance after deductible | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance after deductible | 40% coinsurance after deductible | EAP is 8 visits per calendar year through Spring Health. |
| | Inpatient services | 20% coinsurance after deductible | 40% coinsurance after deductible | Prior Authorization required out-of-network for Mental Health Services (including admission for services at a Residential Treatment facility). |
| **If you are pregnant** | Office visits | 20% coinsurance after deductible | 40% coinsurance after deductible | Routine Pre-natal care is covered no charge in-network. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Childbirth/delivery professional services | 20% coinsurance after deductible | 40% coinsurance after deductible | Prior Authorization required out-of-network for Inpatient stays that exceed normal 48 hours for vaginal delivery or 96 hours for cesarean. |
| | Childbirth/delivery facility services | 20% coinsurance after deductible | 40% coinsurance after deductible | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance after deductible | 40% coinsurance after deductible | Limited to 120 visits per calendar year. In/Out Network Combined. Prior Authorization required out-of-network for Home Health Care for Nutritional Foods, Skilled Nursing by RN or LPN, and Outpatient Private Duty Nursing. |
| | Rehabilitation services | 20% coinsurance after deductible | 40% coinsurance after deductible | Limited to 30 visits each per calendar year combined In/Out Network for Physical, Speech, Occupational Therapy and Manipulative Treatment. |
| | Habilitation services | 20% coinsurance after deductible | 40% coinsurance after deductible | 30 visits each per calendar year combined In/Out Network for Physical, Speech, Occupational Therapy. Autism related only. |
| | Skilled nursing care | 20% coinsurance after deductible | 40% coinsurance after deductible | Limited to 120 days each per calendar year for Skilled Nursing and Inpatient Rehabilitation In/Out Network combined. Prior Authorization required out-of-network. |
| | Durable medical equipment | 20% coinsurance after deductible | 40% coinsurance after deductible | Prior Authorization required out-of-network for DME over $1,000.00 |
| | Hospice services | 20% coinsurance after deductible | 40% coinsurance after deductible | Prior Authorization required out-of-network before admission for Inpatient Stay in a hospice facility. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Not covered on the medical plan. This is covered through the vision plan VSP: 1-800-877-7195 |
| | Children's glasses | Not covered | Not covered | Not covered on the medical plan. This is covered through the vision plan VSP: 1-800-877-7195 |
| | Children's dental check-up | Not covered | Not covered | Not covered on the medical plan. This is covered through the dental plan UHC Dental: 1-877-816-3596 |

**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)
- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility treatment
- Long-term 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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

**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: 1-877-468-1028 or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

**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 1-877-468-1028.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-468-1028.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-468-1028.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-468-1028.

*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** | **$1,600** |
| ■ **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 | $1,600 |
| Copayments | $0 |
| Coinsurance | $1,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,860** |

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

| | |
|---|---|
| ■ **The plan's overall deductible** | **$1,600** |
| ■ **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 | $1,600 |
| Copayments | $0 |
| Coinsurance | $800 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,420** |

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

| | |
|---|---|
| ■ **The plan's overall deductible** | **$1,600** |
| ■ **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 | $1,600 |
| Copayments | $0 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,800** |

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

We do 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 the Civil Rights Coordinator.
**Online:** UHC_Civil_Rights@uhc.com
**Mail**: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the 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 number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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 http://www.hhs.gov/ocr/office/file/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 provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 **(Korean)** 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية ( Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリー
ダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

**ध्यान दें: यदि आप हिंदी (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज** (Summary of Benefits and Coverage, SBC) **के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।**

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការ៉ាបង់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).