NexusACO OAP plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	NexusACO OAP
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☑
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☑
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☑
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☑

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how NexusACO OAP works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$6,000	$6,000
Family	$12,000	$12,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

**After the Annual Medical Deductible has been met.*

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit		
Individual	$6,150	$12,000
Family	$12,300	$24,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

	What You Pay for Services		
Copays ($) and Coinsurance (%) for Covered Health Care Services	**Designated Network**	**Network**	**Out-of-Network**
Preventive Care Services			
Preventive Care Services *Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.* *Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.*		No copay	50%*
Office Services - Sickness & Injury			
Primary Care Physician *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	20%*	50%*	50%*
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	20%*	50%*	50%*
Urgent Care Center Services		20%*	50%*

*After the Annual Medical Deductible has been met.

†Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Virtual Care Services *Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*		No copay	50%*
Emergency Care			
Ambulance Services - Emergency Ambulance			
Air Ambulance		20%*	20%*
Ground Ambulance		20%*	20%*
Ambulance Services - Non-Emergency Ambulance[1]			
Air Ambulance		20%*	20%*
Ground Ambulance		20%*	50%*
Dental Services - Accident Only		20%*	20%*
Emergency Health Care Services - Outpatient[1]		20%*	20%*
Inpatient Care			
Congenital Heart Disease (CHD) Surgeries[1]	20%*	You pay a $500 Inpatient Stay per occurrence deductible prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*	You pay a $500 Inpatient Stay per occurrence deductible prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*
Habilitative Services - Inpatient[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.*	The amount you pay is based on where the covered health care service is provided.		
Hospital - Inpatient Stay[1]	20%*	You pay a $500 Inpatient Stay per occurrence deductible prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*	You pay a $500 Inpatient Stay per occurrence deductible prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1] *Limited to 30 days per Inpatient Stay in a Skilled Nursing Facility.* *Limited to 60 days per year in an Inpatient Rehabilitation Facility.*		20%*	50%*

* After the Annual Medical Deductible has been met.

[1] Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services		
	Designated Network	Network	Out-of-Network
Outpatient Care			
Habilitative Services - Outpatient			
Manipulative Treatment		20%*	50%*
Other habilitative services		20%*	50%*
Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.			
Home Health Care[1]		20%*	50%*
Limited to 60 visits per year.			
One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.			
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing[1]		20%*	50%*
Limited to 18 Definitive Drug Tests per year.			
Limited to 18 Presumptive Drug Tests per year.			
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]		20%*	50%*
Major Diagnostic and Imaging - Outpatient[1]		20%*	50%*
You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.			
Physician Fees for Surgical and Medical Services			
Primary care visits	20%*	50%*	50%*
Specialist care visits	20%*	50%*	50%*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Manipulative Treatment		20%*	50%*
Other rehabilitation services		20%*	50%*
Limited to 20 visits of cognitive rehabilitation therapy per year.			
Limited to 20 visits of occupational therapy per year.			
Limited to 20 visits of physical therapy per year.			
Limited to 20 visits of pulmonary rehabilitation therapy per year.			
Limited to 20 visits of speech therapy per year.			
Limited to 30 visits of post-cochlear implant aural therapy per year.			
Limited to 36 visits of cardiac rehabilitation therapy per year.			

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Scopic Procedures - Outpatient Diagnostic and Therapeutic	20%*	You pay a $250 per occurrence deductible per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*	You pay a $250 per occurrence deductible per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.			
Surgery - Outpatient[1]	20%*	You pay a $250 per occurrence deductible per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*	You pay a $250 per occurrence deductible per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*
Therapeutic Treatments - Outpatient[1]		20%*	50%*
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.			
Supplies and Services			
Diabetes Self-Management Items[1]	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1]	The amount you pay is based on where the covered health care service is provided.		
Durable Medical Equipment (DME), Orthotics and Supplies[1]		20%*	50%*
Limited to 1 insulin pump per year.			
Limited to a single purchase of a type of DME or orthotic every 3 years.			
Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.			
Enteral Nutrition		20%*	50%*
Hearing Aids		20%*	50%*
Limited to a single purchase per hearing impaired ear every 3 years.			
Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.			
Ostomy Supplies		20%*	50%*
Pharmaceutical Products - Outpatient		20%*	50%*
This includes medications given at a doctor's office, or in a covered person's home.			
Prosthetic Devices[1]		20%*	50%*
Limited to a single purchase of each type of prosthetic device every 3 years.			
Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.			

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services		
	Designated Network	Network	Out-of-Network
Urinary Catheters		20%*	50%*
Pregnancy			
Pregnancy - Maternity Services[1]	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient[1]		20%*	50%*
Outpatient and Transitional Care		20%*	50%*
Partial Hospitalization and Transitional Care		20%*	50%*
Other Services			
Autism Spectrum Disorder Services[1]	The amount you pay is based on where the covered health care service is provided.		
Cellular and Gene Therapy[1]	The amount you pay is based on where the covered health care service is provided.		
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.			
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.		
Dental/Anesthesia Services – Hospital Ambulatory Surgery Services[1]	The amount you pay is based on where the covered health care service is provided.		
Fertility Preservation for Iatrogenic Infertility[1]		20%*	50%*
Limited to $20,000 per Covered Person per lifetime.			
Limited to $5,000 for Prescription Drug Products per Covered Person.			
This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.			
Gender Dysphoria[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.		
Hospice Care[1]		20%*	50%*
Kidney Disease Treatment[1]	The amount you pay is based on where the covered health care service is provided.		
Preimplantation Genetic Testing (PGT) and Related Services[1]		20%*	50%*
Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.			
Benefits for related services are limited to one Assisted Reproductive Technology (ART) procedure during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include the Preimplantation Genetic Testing (PGT) for the specific genetic disorder.			

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services		
	Designated Network	Network	Out-of-Network
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.		
Temporomandibular Joint (TMJ) Services[1]	The amount you pay is based on where the covered health care service is provided.		
Transplantation Services	The amount you pay is based on where the covered health care service is provided.		Not covered
Network Benefits must be received from a Designated Provider.			

[*] After the Annual Medical Deductible has been met.
[1] Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Advantage

Annual Pharmacy Deductible	In Network
Individual	See the Annual Medical Deductible section
Family	See the Annual Medical Deductible section

Annual Deductible - Network and Out-of-Network

The Pharmacy Deductible is the amount you pay for pharmacy expenses per year before you begin to receive Pharmacy Benefits.

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail and Specialty Pharmacy Network	Out-of-Network Pharmacy	Mail Order Network Pharmacy**
Tier 1 $	$10*	$10*	$25*
Tier 2 $$	$35*	$35*	$87.50*
Tier 3 $$$	$70*	$70*	$175*

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.