



## HSA Choice Plus \$2500 Deductible



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.welcometouhc.com](http://www.welcometouhc.com) or call 1-844-333-8019. 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 1-844-333-8019 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<u>Network</u> : \$2,500 Individual / \$5,000 Family <u>Non-Network</u> : \$4,500 Individual / \$9,000 Family per calendar year.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive Care</u> and primary care services are covered before you meet your <u>deductible</u> .	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other <u>deductibles</u> for specific services?</b>	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For <u>network provider</u> : \$4,500 Individual / \$6,850 Family For <u>out-of-network providers</u> : \$9,000 Individual / \$13,700 Family per calendar year	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> , the overall family <u>out-of-pocket limits</u> must be met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <b>network provider</b> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-844-333-8019 for a list of <b>network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No	You can see the <b>specialist</b> you choose without a <b>referral</b> .

 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Virtual visits -In <u>Network</u> 30% <u>coinsurance</u> after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or co-ins may apply. No virtual visit coverage for out of <u>network</u> .
	<u>Specialist</u> visit	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization is required out of <u>network</u> for Sleep Studies or benefit reduces to 50% of <u>allowed amount</u> .
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b>  <b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.welcometouhc.com">www.welcometouhc.com</a></b></p>	Generic Drugs (Tier 1)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<p><u>Provider</u> means pharmacy for purposes of this section.  Retail: Up to a 31 day supply.  Mail-Order: Up to a 90 day supply.  Certain drugs may have a Prior Authorization requirement or may result in a higher cost. If you use a <u>non-network</u> Pharmacy, you are responsible for any amount over the <u>allowed amount</u>.  You may be required to use a lower-cost drug(s) prior to benefits under your policy being available. See the website listed for information on drugs covered by your <u>plan</u>.  Not all drugs are covered. Prescription drug costs are subject to the annual <u>deductible</u>. Certain preventive medications (including certain contraceptives) are covered at No Charge.  If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable <u>Copay</u> and/or Coins may be applied.</p>
	Preferred brand drugs (Tier 2)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	
	Non-preferred brand drugs (Tier 3)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	
	<u>Specialty drugs</u> (Tier 4)	Retail: Not covered Mail Order: Not covered	Retail: Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization is required out of <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Network deductible</u> applies
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Network deductible</u> applies.
	<u>Urgent care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization is required out of <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Cognitive Behavioral Therapy provided by AbleTo is covered at 100% no cost share for initial consultation; ongoing therapeutic treatments are payable at 100% after in <u>Network plan deductible</u> is satisfied. AbleTo is a contracted <u>provider</u> for Optum Behavioral services specifically for Cognitive Behavioral Therapy. Prior Authorization is required out of <u>network</u> for certain treatments or benefit reduces to 50% of <u>allowed amount</u> . Prior Authorization is also required out of <u>network</u> for Benefits provided for Applied Behavioral Analysis (ABA) if applicable or benefit reduces to 50% of <u>allowed amount</u> .
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization is required out of <u>network</u> for certain treatments or benefit reduces to 50% of <u>allowed amount</u> .
<b>If you are pregnant</b>	Office visits	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required out of <u>network</u> for Inpatient stays that exceed normal 48 hours for vaginal delivery or 96 hours for cesarean or benefit reduces to 50% of <u>allowed amount</u> . Routine pre-natal care is covered at no charge.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 visits per calendar year. Prior Authorization is required out of <u>network</u> for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN) or benefit reduces to 50% of <u>allowed amount</u> .
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Physical, Speech, Occupational, Pulmonary, Cognitive Rehabilitation Therapy: 20 visits each per calendar year; Cardiac: 36 visits per calendar year. Physical, Speech, Occupational Therapy Visit limit doesn't apply for children under the age of 18.
	<u>Habilitation services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required out of <u>network</u> for certain services provided under <u>Rehabilitation Services</u> and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 days per calendar year. Prior Authorization is required out of <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Covers 1 per type of DME (including repair/replacement) every 3 years. Prior Authorization is required out of <u>network</u> for DME over \$1,000 or benefit reduces to 50% of <u>allowed amount</u> .

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)	
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization is required out of <u>network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of <u>allowed amount</u> .
If your child needs dental or eye care	Children's eye exam	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 exam every 2 calendar years.
	Children's glasses	Not covered	Not covered	No coverage for Children's glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for Children's Dental check-up.

#### 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.)**

<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Child dental check-up</li> <li>• Child vision glasses</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care – Except as covered for Diabetes</li> <li>• Weight loss programs</li> </ul>
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Adult routine vision exam (i.e. refraction)</li> </ul>
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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: 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/](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 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: 1-844-333-8019 or visit [www.myuhc.com](http://www.myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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 1-844-333-8019.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-333-8019.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-333-8019.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-333-8019.

*—————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)

■ <u>The plan's overall deductible</u>	\$2,500
■ <u>Specialist coinsurance</u>	30%
■ <u>Hospital (facility) coinsurance</u>	30%
■ <u>Other coinsurance</u>	30%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,000
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,560</b>

### Managing Joe's type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$2,500
■ <u>Specialist coinsurance</u>	30%
■ <u>Hospital (facility) coinsurance</u>	30%
■ <u>Other coinsurance</u>	30%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$900
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,420</b>

### Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$2,500
■ <u>Specialist coinsurance</u>	30%
■ <u>Hospital (facility) coinsurance</u>	30%
■ <u>Other coinsurance</u>	30%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,600</b>

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](mailto: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).

Summary of ) التنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (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。

