



Choice Exclusive (EPO) Plan

Coverage for: Family | Plan Type: EP1



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, call 1-866-844-4864, or visit welcometouhc.com. 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 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network</u> : \$500 Individual / \$1,000 Family Per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and categories with a <u>copay</u> 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	<u>Network</u> : \$3,000 Individual / \$6,000 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> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See myuhc.com or call 1-866-844-4864 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Specialist</u> visit	\$40 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Tier 1 – Generic	Retail: \$10 <u>copay</u> , <u>deductible</u> does not apply Mail-Order: \$20 <u>copay</u> , <u>deductible</u> does not apply	Not Covered	<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 or Preferred 90 Day Retail Network Pharmacy You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. If you use an <u>out-of-network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . Certain <u>preventive medications</u> (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered.
	Tier 2 – Preferred Brand	Retail: \$35 <u>copay</u> <u>deductible</u> does not apply Mail-Order: \$70 <u>copay</u> <u>deductible</u> does not apply	Not Covered	
	Tier 3 – Non-Preferred Brand	Retail: \$60 <u>copay</u> <u>deductible</u> does not apply	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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)	
		Mail-Order: \$120 <u>copay deductible</u> does not apply		You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <u>copay/service deductible</u> does not apply	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> per visit, <u>deductible</u> does not apply	\$150 <u>copay</u> per visit, <u>deductible</u> does not apply	None
	<u>Emergency medical transportation</u>	No Charge	No Charge	None
	<u>Urgent care</u>	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 <u>copay</u> per admission, <u>deductible</u> does not apply	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	<u>Network</u> Partial hospitalization/intensive outpatient treatment: No Charge
	Inpatient services	\$300 <u>copay</u> per admission, <u>deductible</u> does not apply	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	\$300 <u>copay</u> per admission,	Not Covered	None

* For more information about limitations and exceptions, see the [plan](#) or policy document at welcometouhc.com.

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>deductible</u> does not apply		
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	Not Covered	Limited to 120 visits per calendar year.
	<u>Rehabilitation services</u>	\$40 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Limits per calendar year: Physical, Occupational: 30 visits each; Speech, Cardiac, Pulmonary: 20 visits
	<u>Habilitative services</u>	\$40 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	\$300 <u>copay</u> per admission, <u>deductible</u> does not apply.	Not Covered	Limited to 120 days per calendar year (combined with inpatient rehabilitation).
	<u>Durable medical equipment</u>	No Charge	Not Covered	None
	<u>Hospice services</u>	\$300 Copay per stay, <u>deductible</u> does not apply	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to 1 exam every 24 months.
	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.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care • Glasses 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when travelling outside - the U.S. • Prescription drugs 	<ul style="list-style-type: none"> • Routine foot care – Except as covered for Diabetes • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery-limited to \$10,000 per lifetime • Chiropractic (Manipulative care) – 30 visits per calendar year 	<ul style="list-style-type: none"> • Hearing aids - \$2,500 per ear per calendar year • Infertility treatment - Rx limited to \$50,000 /Medical limited to \$100,000 per lifetime. 	<ul style="list-style-type: none"> • Private duty nursing- 70 visits per calendar year • Routine eye care (adult) - 1 exam per 24 months

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact 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 1-866-844-4864.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-844-4864.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-844-4864.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-866-844-4864 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-844-4864.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-844-4864.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-844-4864.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-844-4864.

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall <u>deductible</u>	\$500	■ The <u>plan's</u> overall <u>deductible</u>	\$500	■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>copay</u>	\$40	■ <u>Specialist</u> <u>copay</u>	\$40	■ <u>Specialist</u> <u>copay</u>	\$40
■ Hospital (facility) <u>copay</u>	\$300	■ Hospital (facility) <u>copay</u>	\$300	■ Hospital (facility) <u>copay</u>	\$300
■ Other <u>coinsurance</u>	0%	■ Other <u>coinsurance</u>	0%	■ Other <u>coinsurance</u>	0%
<p>This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>pre-natal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300	<u>Copayments</u>	\$200	<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$70	Limits or exclusions	\$4,300	Limits or exclusions	\$10
The total Peg would pay is	\$370	The total Joe would pay is	\$4,500	The total Mia would pay is	\$510

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