



HSA Choice Plus Savings Plan

Coverage for: Family | Plan Type: PS1



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 1-866-734-7678 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 <u>deductible</u>? | <u>Network</u> : \$2,500 Individual / \$5,000 Family <u>Out-of-Network</u> : \$4,000 Individual / \$8,000 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> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. |
| Are there services covered before you meet your <u>deductible</u>? | Yes. <u>Preventive care</u> is 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 <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | <u>Network</u> : \$4,000 Individual / \$8,000 Family <u>Out-of-Network</u> : \$7,000 Individual / \$14,000 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> , the overall family <u>out-of-pocket limit</u> must be met |
| What is not included in the <u>out-of-pocket limit</u>? | <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> 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 <u>network provider</u>? | Yes. See myuhc.com or call 1-866-734-7678 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 <u>referral</u> to see a <u>specialist</u>? | 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>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | <u>Specialist visit</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | <u>Preventive care/screening/immunization</u> | No Charge | 40% <u>coinsurance</u> | 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) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> . |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| 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: 20% <u>coinsurance</u> Mail-Order: 20% <u>coinsurance</u> | 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 |
| | Tier 2 – Preferred Brand | Retail: 20% <u>coinsurance</u> Mail-Order: 20% <u>coinsurance</u> | Not Covered | 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. |
| | Tier 3 – Non-Preferred Brand | Retail: 20% <u>coinsurance</u> Mail-Order: 20% <u>coinsurance</u> | Not Covered | 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 preventive medications (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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Prescription drug costs are subject to the annual <u>deductible</u> . <u>Network deductible</u> will be applied to the <u>out-of-network provider</u> and applies to the <u>Network out-of-pocket limit</u> |

* 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) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> . |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> | *20% <u>coinsurance</u> | * <u>Network deductible</u> applies |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | *20% <u>coinsurance</u> | * <u>Network deductible</u> applies |
| | <u>Urgent care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Network Partial hospitalization/intensive outpatient treatment</u> : 20% <u>coinsurance</u> <u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> . |
| | Inpatient services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| If you are pregnant | Office visits | No Charge | 40% <u>coinsurance</u> | <u>Cost sharing</u> does not apply for <u>preventive services</u> . |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 40% <u>coinsurance</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 facility services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Inpatient <u>preauthorization</u> applies <u>out-of-network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of <u>allowed amount</u> . |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Limited to 120 visits per calendar year. <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| | <u>Rehabilitation services</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Limited to 30 visits per therapy, per calendar year <u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> . |

* 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>Habilitative services</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Services are provided under and limits are combined with <u>Rehabilitation Services</u> above. <u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> . |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Limited to 100 days per calendar year (combined with inpatient rehabilitation). <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Covers 1 per type of DME (including repair/replacement) every 3 years. <u>Preauthorization</u> is required <u>out-of-network</u> for DME over \$1,000 or no coverage. |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-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 | No Charge | 40% <u>coinsurance</u> | 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 document</u> .) | | |
| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery– Network limited to 1 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

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

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 1-866-734-7678.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-734-7678.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-866-734-7678.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-866-734-7678 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-734-7678.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-734-7678.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-734-7678.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-866-734-7678.

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 plan's overall deductible | \$2,500 | ■ The plan's overall deductible | \$2,500 | ■ The plan's overall deductible | \$2,500 |
| ■ Specialist coinsurance | 20% | ■ Specialist coinsurance | 20% | ■ Specialist coinsurance | 20% |
| ■ Hospital (facility) coinsurance | 20% | ■ Hospital (facility) coinsurance | 20% | ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% | ■ Other coinsurance | 20% | ■ Other coinsurance | 20% |
| This EXAMPLE event includes services like: Specialist office visits (<i>pre-natal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>) | | This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>) | | This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>) | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| In this example, Peg would pay: <i>Cost Sharing</i> | | In this example, Joe would pay: <i>Cost Sharing</i> | | In this example, Mia would pay: <i>Cost Sharing</i> | |
| Deductibles | \$2,500 | Deductibles | \$1,050 | Deductibles | \$2,500 |
| Copayments | \$0 | Copayments | \$0 | Copayments | \$0 |
| Coinsurance | \$1,500 | Coinsurance | \$0 | Coinsurance | \$60 |
| <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 | \$4,070 | The total Joe would pay is | \$5,350 | The total Mia would pay is | \$2,570 |

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