

## UHC Choice HDHP 90% / 30%



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.MyTHR.org](http://www.MyTHR.org) or call 1-682-236-7236. 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](http://www.healthcare.gov/sbc-glossary) or call 1-877-698-4754 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                                                     | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | Designated Network: \$3,500 Individual / \$6,800 Family<br><u>Network</u> : \$4,000.00 Individual / \$12,000.00 Family<br><u>Non-Network</u> : Not Covered 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> .                                                                                                                  |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. <u>Preventive Care</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 <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>       | Designated Network: \$6,750 Individual / \$13,500 Family<br>For <u>network provider</u> : \$6,750.00 Individual / \$13,500.00 Family per calendar year<br>For <u>out-of-network providers</u> : Not Covered | 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.                                                                                                                                                                                                                                        |
| <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.                                                                                                               | 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 1-877-MYTHRLink 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                                                                                                                                                                                                                |
|---------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | <b>Network Provider</b><br>(You will pay the least) | <b>Network Provider</b><br>(You will pay the least) | <b>Out-of-Network Provider</b><br>(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 | 10% <b>coinsurance</b>                              | 10% <b>coinsurance</b>                              | Not covered                                               | Virtual Visit - In <b>network</b> No Charge by a Designated Virtual <b>Network Provider</b> . No virtual visit coverage for out of <b>network</b> . If you receive services in addition to office visit, additional copays, <b>deductibles</b> , or co-ins may apply. |
|                                                               | <b>Specialist</b> visit                          | 10% <b>coinsurance</b>                              | 10% <b>coinsurance</b>                              | Not covered                                               | If you receive services in addition to office visit, additional copays, <b>deductibles</b> , or co-insurance may apply.                                                                                                                                               |
|                                                               | <b>Preventive care/screening/immunization</b>    | No charge                                           | No charge                                           | Not covered                                               | You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are <b>preventive</b> . Then check what your <b>plan</b> will pay for.                                                                               |

| Common Medical Event                                                                                                                                                              | Services You May Need                          | What You Will Pay                                   |                                                                                                                                          |                                                           | Limitations, Exceptions, & Other Important Information |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------|
|                                                                                                                                                                                   |                                                | <u>Network Provider</u><br>(You will pay the least) | <u>Network Provider</u><br>(You will pay the least)                                                                                      | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                        |
| If you have a test                                                                                                                                                                | <u>Diagnostic test</u> (x-ray, blood work)     | 10% <u>coinsurance</u>                              | 10% after deductible at UHC Network Doctors or freestanding network facility or 70% after deductible at a hospital that is not preferred | Not covered                                               | None                                                   |
|                                                                                                                                                                                   | Imaging (CT/PET scans, MRIs)                   | 10% <u>coinsurance</u>                              | 70% <u>coinsurance</u>                                                                                                                   | Not covered                                               | None                                                   |
| If you need drugs to treat your illness or condition<br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.MyTHR.org">www.MyTHR.org</a> | Generic Drugs (Tier 1)                         | Not covered                                         | Not covered                                                                                                                              | Not covered                                               | None                                                   |
|                                                                                                                                                                                   | Preferred brand drugs (Tier 2)                 | Not covered                                         | Not covered                                                                                                                              | Not covered                                               | None                                                   |
|                                                                                                                                                                                   | Non-preferred brand drugs (Tier 3)             | Not covered                                         | Not covered                                                                                                                              | Not covered                                               | None                                                   |
|                                                                                                                                                                                   | <u>Specialty drugs</u> (Tier 4)                | Not covered                                         | Not covered                                                                                                                              | Not covered                                               | None                                                   |
| If you have outpatient surgery                                                                                                                                                    | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u>                              | 10% after deductible at UHC Network Doctors or freestanding network facility or 70% after deductible at a hospital that is not preferred | Not covered                                               | None                                                   |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                   |                                                                                                                                          |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                    |
|---------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | <u>Network Provider</u><br>(You will pay the least) | <u>Network Provider</u><br>(You will pay the least)                                                                                      | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                                                                                                                           |
|                                                                           | Physician/surgeon fees                    | 10% <u>coinsurance</u>                              | 10% after deductible at UHC Network Doctors or freestanding network facility or 70% after deductible at a hospital that is not preferred | Not covered                                               | None                                                                                                                                                      |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                | 10% <u>coinsurance</u>                              | 10% <u>coinsurance</u>                                                                                                                   | 10% <u>coinsurance</u>                                    | None                                                                                                                                                      |
|                                                                           | <u>Emergency medical transportation</u>   | 10% <u>coinsurance</u>                              | 10% <u>coinsurance</u>                                                                                                                   | 10% <u>coinsurance</u>                                    | None                                                                                                                                                      |
|                                                                           | <u>Urgent care</u>                        | 10% <u>coinsurance</u>                              | 10% <u>coinsurance</u>                                                                                                                   | Not covered                                               | None                                                                                                                                                      |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 10% <u>coinsurance</u>                              | 70% <u>coinsurance</u>                                                                                                                   | Not covered                                               | None                                                                                                                                                      |
|                                                                           | Physician/surgeon fees                    | 10% <u>coinsurance</u>                              | 70% <u>coinsurance</u>                                                                                                                   | Not covered                                               | None                                                                                                                                                      |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 10% <u>coinsurance</u>                              | 10% <u>coinsurance</u>                                                                                                                   | Not covered                                               | Partial <u>Hospitalization</u> /Intensive outpatient treatment In- <u>network</u> 10% co-ins after deductible for THR Preferred/UHC Choice <u>Network</u> |
|                                                                           | Inpatient services                        | 10% <u>coinsurance</u>                              | 10% <u>coinsurance</u>                                                                                                                   | Not covered                                               | None                                                                                                                                                      |
| If you are pregnant                                                       | Office visits                             | 10% <u>coinsurance</u>                              | 10% <u>coinsurance</u>                                                                                                                   | Not covered                                               |                                                                                                                                                           |
|                                                                           | Childbirth/delivery professional services | 10% <u>coinsurance</u>                              | 70% <u>coinsurance</u>                                                                                                                   | Not covered                                               |                                                                                                                                                           |

| Common Medical Event                                                  | Services You May Need                 | What You Will Pay                                   |                                                     |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                       | <u>Network Provider</u><br>(You will pay the least) | <u>Network Provider</u><br>(You will pay the least) | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                                                                                                                                                                                                                                                |
|                                                                       | Childbirth/delivery facility services | 10% <u>coinsurance</u>                              | 70% <u>coinsurance</u>                              | 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) |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>               | 10% <u>coinsurance</u>                              | 10% <u>coinsurance</u>                              | Not covered                                               | 100 visits per calendar year, combined per person THR Preferred/UHC Choice <u>Network</u>                                                                                                                                                                                      |
|                                                                       | <u>Rehabilitation services</u>        | 10% <u>coinsurance</u>                              | 10% <u>coinsurance</u>                              | Not covered                                               | 60 visits combined per person for Physical, Speech/Occupational; 36 visits/Cardiac, 20 visits/Pulmonary calendar year<br>Visit limits do not apply to members with a behavioral diagnosis<br>THR Preferred/UHC Choice <u>Network</u>                                           |
|                                                                       | <u>Habilitation services</u>          | Not covered                                         | Not covered                                         | Not covered                                               | <u>Habilitation Services</u> is not covered.                                                                                                                                                                                                                                   |
|                                                                       | <u>Skilled nursing care</u>           | 10% <u>coinsurance</u>                              | 10% <u>coinsurance</u>                              | Not covered                                               | 60 days per calendar year combined per person THR Preferred/UHC Choice <u>Network</u>                                                                                                                                                                                          |
|                                                                       | <u>Durable medical equipment</u>      | 10% <u>coinsurance</u>                              | 10% <u>coinsurance</u>                              | Not covered                                               | None                                                                                                                                                                                                                                                                           |
|                                                                       | <u>Hospice services</u>               | 10% <u>coinsurance</u>                              | 10% <u>coinsurance</u>                              | Not covered                                               | None                                                                                                                                                                                                                                                                           |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                   | Not covered                                         | Not covered                                         | Not covered                                               | Child routine vision exam is not covered.                                                                                                                                                                                                                                      |
|                                                                       | Children's glasses                    | Not covered                                         | Not covered                                         | Not covered                                               | Child glasses are not covered.                                                                                                                                                                                                                                                 |
|                                                                       | Children's dental check-up            | Not covered                                         | Not covered                                         | Not covered                                               | Child dental check-up is not covered.                                                                                                                                                                                                                                          |

### 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>• Adult routine vision exam (i.e. refraction)</li><li>• Cosmetic Surgery</li><li>• Dental Care (Adult)</li></ul> | <ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li></ul> | <ul style="list-style-type: none"><li>• Routine foot care</li><li>• Weight loss programs</li></ul> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|

#### 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>• Bariatric Surgery</li></ul> | <ul style="list-style-type: none"><li>• Chiropractic care</li><li>• Hearing aids</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment</li></ul> |
|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|

**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: 1-877-MYTHRLink 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? No**

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-MYTHRLink.

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

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-MYTHRLink.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-877-MYTHRLink uff.

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

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-877-MYTHRLink.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-MYTHRLink.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-877-MYTHRLink.

—————*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 <u>plan's</u> overall deductible   | \$3,500.00 |
| ■ <u>Specialist coinsurance</u>          | 70%        |
| ■ Hospital (facility) <u>coinsurance</u> | 70%        |
| ■ Other <u>coinsurance</u>               | 70%        |

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 | \$12,800 |
|--------------------|----------|

In this example, Peg would pay:

| <u>Cost Sharing</u>        |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$3,500 |
| <u>Copayments</u>          | \$0     |
| <u>Coinsurance</u>         | \$2,790 |
| <i>What isn't covered</i>  |         |
| Limits or exclusions       | \$70    |
| The total Peg would pay is | \$6,360 |

### Managing Joe's type 2 Diabetes

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

|                                          |            |
|------------------------------------------|------------|
| ■ The <u>plan's</u> overall deductible   | \$3,500.00 |
| ■ <u>Specialist coinsurance</u>          | 70%        |
| ■ Hospital (facility) <u>coinsurance</u> | 70%        |
| ■ Other <u>coinsurance</u>               | 70%        |

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 | \$5,700 |
|--------------------|---------|

In this example, Joe would pay:

| <u>Cost Sharing</u>        |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$800   |
| <u>Copayments</u>          | \$0     |
| <u>Coinsurance</u>         | \$180   |
| <i>What isn't covered</i>  |         |
| Limits or exclusions       | \$4,300 |
| The total Joe would pay is | \$5,300 |

### Mia's Simple Fracture

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

|                                          |            |
|------------------------------------------|------------|
| ■ The <u>plan's</u> overall deductible   | \$3,500.00 |
| ■ <u>Specialist coinsurance</u>          | 70%        |
| ■ Hospital (facility) <u>coinsurance</u> | 70%        |
| ■ Other <u>coinsurance</u>               | 70%        |

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 | \$2,900 |
|--------------------|---------|

In this example, Mia would pay:

| <u>Cost Sharing</u>        |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$2,500 |
| <u>Copayments</u>          | \$0     |
| <u>Coinsurance</u>         | \$200   |
| <i>What isn't covered</i>  |         |
| Limits or exclusions       | \$10    |
| The total Mia would pay is | \$2,710 |