




Choice Plus 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 1-866-633-2446 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: |
|---|--|---|
| <p>What is the overall deductible?</p> | <p><u>Network</u>: \$1,000 Individual / \$3,000 Family <u>Out-of-Network</u>: \$3,000 Individual / \$6,000 Family Per policy year.</p> | <p>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>.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes. <u>Preventive care</u> and categories with a <u>copay</u> are covered before you meet your <u>deductible</u>.</p> | <p>This <u>plan</u> covers some items and services even if you haven't yet met the annual <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 services at www.healthcare.gov/coverage/preventive-care-benefits/.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>No.</p> | <p>You don't have to meet <u>deductibles</u> for specific services.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p><u>Network</u>: \$3,000 Individual / \$6,000 Family <u>Out-of-Network</u>: \$6,000 Individual / \$9,000 Family Per policy year.</p> | <p>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.</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p><u>Premiums</u>, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>Prenotification</u> for services.</p> | <p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p> |
| <p>Will you pay less if you use a network provider?</p> | <p>Yes. See myuhc.com or call 1-866-633-2446 for a list of <u>network providers</u>.</p> | <p>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 charge</u> 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.</p> |
| <p>Do you need a referral to see a specialist?</p> | <p>No.</p> | <p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p> |



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. | 40% <u>coinsurance</u> | 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. | 40% <u>coinsurance</u> | 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 | 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) | No Charge | 40% <u>coinsurance</u> | <u>Prenotification</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) | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Prenotification</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 | Tier 1 – Your Lowest Cost Option | Not Covered | Not Covered | No coverage for prescription drugs with UnitedHealthcare. |
| | Tier 2 – Your Mid-Range Cost Option | Not Covered | Not Covered | |
| | Tier 3 – Your Mid-Range Cost Option | Not Covered | Not Covered | |
| | Tier 4 – Your Highest Cost Option | Not Applicable | Not Applicable | |

* 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) | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$250 <u>copay</u> per visit, <u>deductible</u> does not apply. | \$250 <u>copay</u> per visit, <u>deductible</u> does not apply. | None |
| | <u>Emergency medical transportation</u> | 10% <u>coinsurance</u> | *10% <u>coinsurance</u> | * <u>Network deductible</u> applies |
| | <u>Urgent care</u> | \$45 <u>copay</u> per visit, <u>deductible</u> does not apply. | \$45 <u>copay</u> per visit, <u>deductible</u> does not apply. | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Prenotification</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| | Physician/surgeon fees | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | 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. | 40% <u>coinsurance</u> | <u>Prenotification</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> . |
| | Inpatient services | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Prenotification</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> . 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 | 10% <u>coinsurance</u> | 40% <u>coinsurance</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) | |
| | Childbirth/delivery facility services | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | Inpatient <u>Prenotification</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> | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | Limited to 60 visits per policy year. <u>Prenotification</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| | <u>Rehabilitation services</u> | PCP: \$20 <u>copay</u> per visit, <u>deductible</u> does not apply. Specialist: \$40 <u>copay</u> per visit, <u>deductible</u> does not apply. | 40% <u>coinsurance</u> | Limits per policy year: Physical/Occupational/ Speech: combined limit 60 visits; Cardiac: 36 visits; Pulmonary: 20 visits. <u>Prenotification</u> required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> . |
| | <u>Habilitative services</u> | PCP: \$20 <u>copay</u> per visit, <u>deductible</u> does not apply. Specialist: \$40 <u>copay</u> per visit, <u>deductible</u> does not apply. | 40% <u>coinsurance</u> | Services are provided under and limits are combined with <u>Rehabilitation Services</u> above. <u>Prenotification</u> required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> . |
| | <u>Skilled nursing care</u> | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | Limited to 60 days per policy year (combined with inpatient rehabilitation). <u>Prenotification</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| | <u>Durable medical equipment</u> | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | Covers 1 per type of DME (including repair/replacement) every 3 years. <u>Prenotification</u> is required <u>out-of-network</u> for DME over \$1,000 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>Hospice services</u> | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Prenotification</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 | Not Covered | Not Covered | No coverage for Children's eye exams. |
| | 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"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care • Glasses | <ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when travelling outside - the U.S. • Prescription drugs | <ul style="list-style-type: none"> • Private duty nursing • Routine eye care • 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 plan document.)

- | | |
|--|--|
| <ul style="list-style-type: none"> • Chiropractic (Manipulative care) – 20 visits per policy year | <ul style="list-style-type: none"> • Hearing aids - \$5,000 per policy year |
|--|--|

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 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-633-2446.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-866-633-2446 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2446.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2446.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-633-2446.

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) |
|--|---|--|
|--|---|--|

| | | |
|--|--|--|
| <ul style="list-style-type: none"> ■ The plan's overall deductible \$1,000 ■ Specialist copay \$40 ■ Hospital (facility) coinsurance 10% ■ Other coinsurance 10% | <ul style="list-style-type: none"> ■ The plan's overall deductible \$1,000 ■ Specialist copay \$40 ■ Hospital (facility) coinsurance 10% ■ Other coinsurance 10% | <ul style="list-style-type: none"> ■ The plan's overall deductible \$1,000 ■ Specialist copay \$40 ■ Hospital (facility) coinsurance 10% ■ Other coinsurance 10% |
|--|--|--|

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*)

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*)

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 | \$12,700 |
|---------------------------|-----------------|

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,000 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$900 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,960 |

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$150 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$350 |

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,000 |
| <u>Copayments</u> | \$400 |
| <u>Coinsurance</u> | \$20 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,420 |

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