Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

HSA Choice Plus Plan

Coverage Period: 01/01/2024 - 12/31/2024
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 1-866-734-7670 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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>Network: $1,750 Individual / $3,500 Family</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: $3,500 Individual / $7,000 Family Per calendar year.</td>
<td></td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care is covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Network: $4,000 Individual / $8,000 Family</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. Deductible and Medical co-pays accumulate towards the Medical OOPM. Rx co-pays accumulate towards the Rx OOPM.</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: $8,000 Individual / $16,000 Family Per calendar year.</td>
<td></td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover and penalties for failure to obtain preauthorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See myuhc.com or call 1-855-213-6757 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td><strong>Network Provider (You will pay the least)</strong>: $10 copay per visit</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: 40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$15 copay per visit</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>0% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).
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</tr>
</thead>
</table>
| **If you need drugs to treat your illness or condition** | Tier 1 – Your Lowest Cost Option | Retail: 15% coinsurance but not less than $15 and not more than $30  
Specialty: 15% coinsurance but not less than $15 and not more than $30  
Mail-Order: $30 copay 31 days Specialty: $30 copay | Retail: 15% coinsurance but not less than $15 and not more than $30  
Specialty: 15% coinsurance but not less than $15 and not more than $30  
Mail-Order: $30 copay 31 days Specialty: $30 copay | Provider means pharmacy for purposes of this section.  
Retail: Up to a 31-day supply.  
Mail-Order: Up to a 90-day supply.  
You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.  
Certain drugs may have a prenotification requirement or may result in a higher cost.  
If you use a non-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.  
Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. 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.  
If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Prescription drug costs are subject to the annual deductible. Deductible does not apply to drugs on the List of Preventive Medications.  
Network deductible will be applied to the out-of-network provider and applies to the Network out-of-pocket limit |
| More information about prescription drug coverage is available at welcometouhc.com | Tier 2 – Your Mid-Range Cost Option | Retail: 20% coinsurance but not less than $30 and not more than $50  
Specialty: 20% coinsurance but not less than $30 and not more than $50  
Mail-Order: $60 copay 31 days Specialty: $60 copay | Retail: 20% coinsurance but not less than $30 and not more than $50  
Specialty: 20% coinsurance but not less than $30 and not more than $50  
Mail-Order: $60 copay 31 days Specialty: $60 copay | |
| | Tier 3 – Your Mid-Range Cost Option | Retail: 30% coinsurance but not less than $45 and not more than $75  
Specialty: 30% coinsurance but not less than $45 and not more than $75  
Mail-Order: $90 copay 31 days Specialty: $90 copay | Retail: 30% coinsurance but not less than $45 and not more than $75  
Specialty: 30% coinsurance but not less than $45 and not more than $75  
Mail-Order: $90 copay 31 days Specialty: $90 copay | |
| | 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.
<table>
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<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$150 copay per visit</td>
<td>*$150 copay per visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>*20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$10 copay per visit</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No Charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.
## Limitations, Exceptions, & Other Important Information

### Habilitative services
- **Network Provider (You will pay the least):** 20% coinsurance
- **Out-of-Network Provider (You will pay the most):** 40% coinsurance

Services are provided under and limits are combined with Rehabilitation Services above. Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.

### Skilled nursing care
- **Network Provider (You will pay the least):** 20% coinsurance
- **Out-of-Network Provider (You will pay the most):** 40% coinsurance

Limited to 180 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.

### Durable medical equipment
- **Network Provider (You will pay the least):** 20% coinsurance
- **Out-of-Network Provider (You will pay the most):** 40% coinsurance

Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or no coverage.

### Hospice services
- **Network Provider (You will pay the least):** 20% coinsurance
- **Out-of-Network Provider (You will pay the most):** 40% coinsurance

Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.

### If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s eye exam</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Limited to 1 exam per every 24 months</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>No coverage for Children’s glasses.</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>No coverage for Children’s Dental check-up.</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover
- Cosmetic surgery
- Dental care
- Glasses
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- 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.)
- Acupuncture – 24 visits per calendar year combined with Chiropractic services
- Chiropractic (Manipulative care) – 24 visits per calendar year combined with Acupuncture services
- Hearing aids - $10,000 per calendar year
- Routine eye care (adult) - 1 exam per 24 months
- Fertility - $25,000 Medical Lifetime Maximum and $10,000 Pharmacy Lifetime Maximum
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:
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijjigo holne’ 1-866-734-7670.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>The plan’s overall deductible $1,750</td>
<td>The plan’s overall deductible $1,750</td>
<td>The plan’s overall deductible $1,750</td>
</tr>
<tr>
<td>Specialist copay $15</td>
<td>Specialist copay $15</td>
<td>Specialist copay $15</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance 20%</td>
<td>Hospital (facility) coinsurance 20%</td>
<td>Hospital (facility) coinsurance 20%</td>
</tr>
<tr>
<td>Other coinsurance 20%</td>
<td>Other coinsurance 20%</td>
<td>Other coinsurance 20%</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
<th>Total Example Cost</th>
<th>$5,600</th>
<th>Total Example Cost</th>
<th>$2,800</th>
</tr>
</thead>
</table>

In this example, Peg would pay:
- Deductibles $1,750
- Copayments $0
- Coinsurance $1,900

What isn’t covered
- Limits or exclusions $60

The total Peg would pay is $3,710

In this example, Joe would pay:
- Deductibles $300
- Copayments $70
- Coinsurance $1,100

What isn’t covered
- Limits or exclusions $30

The total Joe would pay is $1,500

In this example, Mia would pay:
- Deductibles $1,000
- Copayments $200
- Coinsurance $0

What isn’t covered
- Limits or exclusions $30

The total Mia would pay is $1,200

The plan would be responsible for the other costs of these EXAMPLE covered services.
We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** UHC_Civil_Rights@uhc.com

**Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf)

**Complaint forms are available at [http://www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).**

**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.
알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 헤택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benefisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чьи родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

اتباع: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال برقم الهاتف المجاني المدرج داخل مخطوط المزارة والتحليلة هنا (Summary of Benefits and Coverage, SBC).

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all’interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリー ダイヤルにてお電話ください。
为一体的，你们的文件中包含了关于选择医疗服务的信息。请确保理解并根据需要采取行动。

Note: The document contains information about choosing medical services. Please ensure understanding and take appropriate actions as needed.