

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [welcometouhc.com](http://welcometouhc.com) or by calling 1-866-633-2446.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: <b>\$1,300</b> *Individual / <b>\$2,600</b> Family Non-Network: <b>\$2,600</b> *Individual / <b>\$5,200</b> Family Per calendar year. Services listed below as "No Charge" do not apply to the <b>deductible</b> . *Doesn't apply if policy covers 2+ people.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Network: <b>\$4,000</b> *Individual / <b>\$8,000</b> Family Non-Network: <b>\$8,000</b> *Individual / <b>\$16,000</b> Family *Doesn't apply if policy covers 2+ people.	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	<b>Premium</b> , balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain Pre-notification for services.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of <b>network providers</b> , see <a href="http://myuhc.com">myuhc.com</a> or call 1-800-996-2078	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a specialist?	No.	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b> .

**Questions:** Call 1-866-633-2446 or visit us at [welcometouhc.com](http://welcometouhc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf](http://cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf) or call the phone number above to request a copy.



Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Primary care visit to treat an injury or illness	20% co-ins after ded.	40% co-ins after ded.	None
	Specialist visit	20% co-ins after ded.	40% co-ins after ded.	None
	Other practitioner office visit	20% co-ins after ded.	40% co-ins after ded.	Spinal manipulation includes diagnosis and related services that are limited to one visit and treatment per day. Any combination of Network and Non-Network Benefits for Spinal Treatment is limited to \$500 per calendar year.
	Preventive care / screening / immunization	No Charge	40% co-ins after ded.	Includes preventive health services specified in the health care reform law. No coverage non-network.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	20% co-ins after ded.	40% co-ins after ded.	None
	Imaging (CT / PET scans, MRIs)	20% co-ins after ded.	40% co-ins after ded.	None
	Tier 1 – Your Lowest-Cost Option	Retail 31&90 day: 20% co-ins after ded. Mail-Order: 20% co-ins after ded. Diabetic Pharmacy: Retail 31&90 day: 20% co-ins after ded.	Retail 31&90 day: 50% co-ins after ded.	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 Pre-notification

**Summary of Benefits and Coverage: What This Plan Covers & What it Costs**    **Coverage for:** Employee & Family    **Plan Type:** PS1

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
		Mail-Order: 20% co-ins after ded.		requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Prescription drug costs are subject to the annual deductible.
	Tier 2 – Your Midrange-Cost Option		Retail 31&90 day: 50% co-ins after ded.	
	Tier 3 – Your Highest-Cost Option	Retail 31&90 day: 20% co-ins after ded. Mail-Order: 20% co-ins after ded. Diabetic Pharmacy: Retail 31&90 day: 20% co-ins after ded. Mail-Order: 20% co-ins after ded.	Retail 31&90 day: 50% co-ins after ded.	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	
	Facility fee (e.g., ambulatory surgery center)	20% co-ins after ded.	40% co-ins after ded.	None
	Physician / surgeon fees	20% co-ins after ded.	40% co-ins after ded.	None
<b>If you need immediate medical</b>	Emergency room services	20% co-ins after ded.	*20% co-ins after ded.	*Network deductible applies

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<b>attention</b>	Emergency medical transportation	20% co-ins after ded.	*20% co-ins after ded.	*Network deductible applies
	Urgent care	20% co-ins after ded.	40% co-ins after ded.	None
	Facility fee (e.g., hospital room)	20% co-ins after ded.	40% co-ins after ded.	Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Physician / surgeon fees	20% co-ins after ded.	40% co-ins after ded.	None
	Mental / Behavioral health outpatient services	20% co-ins after ded.	40% co-ins after ded.	None
	Mental / Behavioral health inpatient services	20% co-ins after ded.	40% co-ins after ded.	Pre-notification is required or benefit reduces to 50% of eligible expenses.
	Substance use disorder outpatient services	20% co-ins after ded.	40% co-ins after ded.	None
	Substance use disorder inpatient services	20% co-ins after ded.	40% co-ins after ded.	Pre-notification is required or benefit reduces to 50% of eligible expenses.
<b>If you are pregnant</b>	Prenatal and postnatal care	20% co-ins after ded.	40% co-ins after ded.	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	20% co-ins after ded.	40% co-ins after ded.	Pre notification may be required for longer lengths of stay that exceed the Newborns' and Mothers' Health Protection Act of 1996.
	Home health care	20% co-ins after ded.	40% co-ins after ded.	
	Rehabilitation services	20% co-ins after ded.	40% co-ins after ded.	Limits per calendar year: physical, speech, occupational – 10 visits; cardiac – post cochlear

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
				implant aural, pulmonary rehab, cardiac rehab therapy – Unlimited visits.
	Habilitative services	20% co-ins after ded.	40% co-ins after ded.	Limits are combined with Rehabilitation Services limits listed above.
	Skilled nursing care	20% co-ins after ded.	40% co-ins after ded.	Pre-notification is required non-network or benefits reduces to 50% of eligible expenses. Any combination of Network Benefits and Non-Network Benefits for Inpatient Rehabilitation is limited to 60 days per calendar year. Skilled nursing has unlimited visits.
	Durable medical equipment	20% co-ins after ded.	40% co-ins after ded.	
	Hospice service	20% co-ins after ded.	40% co-ins after ded.	Limited to 180 days per calendar year. Inpatient Pre-notification is required for non-network or benefit reduces to 50% of eligible expenses.
	Eye exam	Not Covered	Not Covered	No coverage for eye exams.
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-up.

**Excluded Services & Other Covered Services:**

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# HSA Choice Plus Active Non-Uniformed CDHP Plan

Coverage Period: 01/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What This Plan Covers & What it Costs    Coverage for: Employee & Family    Plan Type: PS1

<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Adult/Child)</li> <li>Glasses (Adult/Child)</li> <li>Hearing aids</li> <li>Infertility treatment</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 eye care (Adult/Child)</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>
<b>Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)</b>			
<ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Acupuncture Services</li> </ul>			

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or visit [www.myuhc.com](http://www.myuhc.com).

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.

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.

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

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

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



- Amount owed to providers: \$7,540
- Plan pays \$5,040
- Patient pays \$2,500

### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40

### Patient pays:

Deductibles	\$1,300
Copays	\$0
Coinsurance	\$1,000
Limits or exclusions	\$200

- Amount owed to providers: \$5,400
- Plan pays \$3,260
- Patient pays \$2,140

### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100

### Patient pays:

Deductibles	\$1,300
Copays	\$0
Coinsurance	\$800
Limits or exclusions	\$40
<b>Total</b>	<b>\$2,140</b>

## Questions and answers about Coverage Examples:

<p><b>What are some of the assumptions behind the Coverage Examples?</b></p> <ul style="list-style-type: none"> <li>• Costs don't include <b>premiums</b>.</li> <li>• Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.</li> <li>• The patient's condition was not excluded.</li> <li>• All services and treatments started and ended in the same coverage period.</li> <li>• There are no other medical expenses for any member covered under this plan.</li> <li>• Out-of-pocket expenses are based only on treating the condition in the example.</li> <li>• The patient received all care from in-network <b>providers</b>. If the patient had received care from out-of-network <b>providers</b>, costs would have been higher.</li> <li>• If other than individual coverage, the Patient Pays amount may be more.</li> </ul>	<p><b>What does a Coverage Example show?</b></p> <p>For each treatment situation, the Coverage Example helps you see how <b>deductibles</b>, <b>copayments</b>, and <b>coinsurance</b> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.</p>	<p><b>Can I use Coverage Examples to compare plans?</b></p> <p>✓ <b>Yes.</b> When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.</p>
<p><b>Does the Coverage Example predict my own care needs?</b></p> <p>✗ <b>No.</b> Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.</p>	<p><b>Does the Coverage Example predict my future expenses?</b></p> <p>✗ <b>No.</b> Coverage Examples are <b>not</b> cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your <b>providers</b> charge, and the reimbursement your health plan allows.</p>	<p><b>Are there other costs I should consider when comparing plans?</b></p> <p>✓ <b>Yes.</b> An important cost is the <b>premium</b> you pay. Generally, the lower your <b>premium</b>, the more you'll pay in out-of-pocket costs, such as <b>copayments</b>, <b>deductibles</b>, and <b>coinsurance</b>. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.</p>

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