### Important Questions | Answers | Why This Matters:
---|---|---
**What is the overall deductible?** | Network: $500 Individual / $1,000 Family  
Non-Network: $500 Individual / $1,000 Family  
Per calendar year. Copays, prescription drugs, and services listed below as “No Charge” do not apply to the deductable. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**. |
**Are there other deductibles for specific services?** | No. | You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
**Is there an out-of-pocket limit on my expenses?** | Network: $3,000 Individual / $6,000 Family  
Non-Network: $10,000 Individual / $20,000 Family  
Family | The **out-of-pocket limit** 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 out-of-pocket limit?** | **Premium**, prescription drugs, balance-billed charges, health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**. |
**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 network of providers?** | Yes. For a list of network providers, see [myuhc.com](http://myuhc.com) or call 1-888-585-4961. | If you use an in-network doctor or other health care provider, 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 provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |
**Do I need a referral to see a specialist?** | No. | You can see the specialist 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 excluded services. |

**Questions:** Call 1-888-585-4961 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.
### Summary of Benefits and Coverage: What This Plan Covers & What it Costs

**Coverage Period:** 01/01/2019 – 12/31/2019

**Coverage for:** Employee & Family

**Plan Type:** PS1

#### Copayments
Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

#### Coinsurance
Coinsurance is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your deductible.

The amount the plan pays for covered services is based on the **allowed amount**. If a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called balance billing.)

This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$35 copay per visit</td>
<td>40% co-ins after ded.</td>
<td>Virtual visits (Telehealth) – $10 copay per visit by a designated virtual network provider. No virtual coverage out-of-network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$35 copay per visit</td>
<td>40% co-ins after ded.</td>
<td>If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$25 copay per visit after ded.</td>
<td>40% co-ins after ded.</td>
<td>Cost share applies to manipulative (chiropractic) and acupuncture services only and is limited to 12 visits per calendar year.</td>
</tr>
<tr>
<td>Preventive care / screening / immunization</td>
<td>$35 copay per visit</td>
<td>Not Covered</td>
<td>Most women’s preventive visits are covered at $0 copay. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$35 copay per visit</td>
<td>40% co-ins after ded.</td>
<td>Pre-authorization is required non-network.</td>
</tr>
<tr>
<td>Imaging (CT / PET scans, MRIs)</td>
<td>20% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>None</td>
</tr>
</tbody>
</table>
# Choice Plus PPO 500 Plan

**Coverage Period:** 01/01/2019 – 12/31/2019  
**Coverage for:** Employee & Family  
**Plan Type:** PS1

## Summary of Benefits and Coverage: What This Plan Covers & What it Costs

**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** |
--- | --- | --- | --- | --- |
If you need drugs to treat your illness or condition | Tier 1 – Your Lowest-Cost Option | Retail: $10 copay  
Mail-Order: $20 copay | Retail: $10 copay then 25% co-ins |  
Tier 2 – Your Midrange-Cost Option | Retail: $20 copay  
Mail-Order: $40 copay | Retail: $20 copay then 25% co-ins |  
Tier 3 – Your Highest-Cost Option | Retail: $35 copay  
Mail Order: $70 copay | Retail: $35 copay then 25% co-ins |  
Tier 4 – Additional High-Cost Options | Not Applicable | Not Applicable |  
More information about prescription drug coverage is available at myuhc.com

## Limitations & Exceptions
- 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-authorization 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.
- See the website listed for information on drugs covered by your plan. Not all drugs are covered.

### If you have outpatient surgery
- Facility fee (e.g., ambulatory surgery center): 20% co-ins after ded.  
- Physician / surgeon fees: 20% co-ins after ded.

### If you need immediate medical attention
- Emergency room services: $100 copay per visit  
- Emergency medical transportation: 20% co-ins after ded.  
  
*Network deductible applies
# Summary of Benefits and Coverage

**Choice Plus PPO 500 Plan**  
**Coverage Period:** 01/01/2019 – 12/31/2019  
**Coverage for:** Employee & Family  
**Plan Type:** PS1

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td></td>
<td>$35 copay per visit</td>
<td>40% co-ins after ded.</td>
<td>If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.</td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td></td>
<td>$250 copay per inpatient stay, then 20% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Pre-authorization is required non-network.</td>
</tr>
<tr>
<td>Physician / surgeon fees</td>
<td></td>
<td>20% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have mental health, or behavioral health needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental / Behavioral health outpatient services</td>
<td></td>
<td>$35 copay per visit</td>
<td>40% co-ins after ded.</td>
<td>Pre-authorization is required non-network for certain services.</td>
</tr>
<tr>
<td>Mental / Behavioral health inpatient services</td>
<td></td>
<td>$250 copay per inpatient stay, then 20% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Pre-authorization is required non-network.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal and postnatal care</td>
<td></td>
<td>$35 copay, initial visit</td>
<td>40% co-ins after ded.</td>
<td>Additional copays, deductibles, or co-ins may apply depending on services rendered.</td>
</tr>
<tr>
<td>Delivery and all inpatient services</td>
<td></td>
<td>$250 copay per inpatient stay, then 20% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Your cost for inpatient services only. Delivery Services cost share is reflected in &quot;Physician/surgeon fees&quot; above.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td></td>
<td>0% co-ins after ded.</td>
<td>Not Covered</td>
<td>Limited to 100 visits per calendar year.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td></td>
<td>$35 copay per outpatient visit</td>
<td>40% co-ins after ded.</td>
<td>Outpatient rehabilitation services are unlimited per calendar year.</td>
</tr>
<tr>
<td>Habilitative services</td>
<td></td>
<td>$35 copay per outpatient visit</td>
<td>40% co-ins after ded.</td>
<td>Limits are combined with Rehabilitation Services limits listed above.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>20% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Limited to 100 days per calendar year (combined with inpatient rehabilitation).</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your Cost If You Use a Network Provider</td>
<td>Your Cost If You Use a Non-Network Provider</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------------</td>
<td>----------------------------------------</td>
<td>--------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Pre-authorization is required non-network for DME over $1,000. Covers 1 per type of DME (including repair/replacement) every 3 years.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>0% co-ins after ded.</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>

**If your child needs dental or eye care**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>No coverage for eye exams.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>No coverage for glasses.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>No coverage for dental check-up.</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover** (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult/Child)
- Glasses (Adult/Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Routine eye care (Adult/Child)
- Weight loss programs

**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.)

- Acupuncture – 12 visits per calendar year
- Bariatric surgery
- Chiropractic (Manipulative care) – 12 visits per calendar year
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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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 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:
Navajo (Dine): Dinek’ehgo shika at’ohwo shi’ininsingo, kwiyi’gi holne’ 1-888-585-4961.

---To see examples of how this plan might cover costs for a sample medical situation, see the next page.---
### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,040
- **Patient pays:** $1,500

**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
  
**Total:** $7,540

**Patient pays:**
- Deductibles: $500
- Copays: $700
- Coinsurance: $100
- Limits or exclusions: $200
  
**Total:** $1,500

---

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,660
- **Patient pays:** $1,740

**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
  
**Total:** $5,400

**Patient pays:**
- Deductibles: $500
- Copays: $1,200
- Coinsurance: $0
- Limits or exclusions: $40
  
**Total:** $1,740

---

**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.

---

**This is not a cost estimator.**

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.
### Questions and answers about Coverage Examples:

<table>
<thead>
<tr>
<th>What are some of the assumptions behind the Coverage Examples?</th>
<th>What does a Coverage Example show?</th>
<th>Can I use Coverage Examples to compare plans?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Costs don’t include premiums.</td>
<td>For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance 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.</td>
<td>✓ Yes. 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 &quot;Patient Pays&quot; box in each example. The smaller that number, the more coverage the plan provides.</td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The patient’s condition was not an excluded or preexisting condition.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• All services and treatments started and ended in the same coverage period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• There are no other medical expenses for any member covered under this plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Out-of-pocket expenses are based only on treating the condition in the example.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If other than individual coverage, the Patient Pays amount may be more.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Does the Coverage Example predict my own care needs?

✓ No. 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.

### Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not 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 providers charge, and the reimbursement your health plan allows.

### Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. 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.

### Questions:

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