




Choice Active Plan

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 1-866-633-2474 or visit [welcometouhc.com](http://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/](http://www.healthcare.gov/sbc-glossary/) or call 1-866-633-2474 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events Chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	No.	See the Common Medical Events Chart below for your costs for services this <u>plan</u> covers.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Network: <b>\$3,500</b> Individual / <b>\$7,000</b> Family Per calendar year.	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.
What is not included in the <u>out-of-pocket limit</u> ?	<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 limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://myuhc.com">myuhc.com</a> or call 1-866-633-2474 for a list of <u>network providers</u> .	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.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Virtual visits - No Charge per visit by a Designated Virtual <u>Network Provider</u> . Office Visit cost share applies to any other Telehealth service based on <u>provider</u> type. 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	Tier 1: \$30 <u>copay</u> per visit, <u>deductible</u> does not apply. Tier 2: \$40 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	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	Not Covered	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	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$100 <u>copay</u> per service, then 10% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not Covered	None

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://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)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://welcometouhc.com">welcometouhc.com</a></p>	Tier 1 – Your Lowest Cost Option	<p>Retail: 10% <u>coinsurance</u> but not less than \$10 and not more than \$50 (1-31 day supply), <u>deductible</u> does not apply.</p> <p>10% <u>coinsurance</u> but not less than \$10 and not more than \$100 (32-90 day supply), <u>deductible</u> does not apply.</p> <p>Mail-Order: 10% <u>coinsurance</u> but not less than \$10 and not more than \$100 (90 day supply), <u>deductible</u> does not apply.</p> <p>Specialty: 10% <u>coinsurance</u> but not less than \$20 and not more than \$100 (1-30 day supply), <u>deductible</u> does not apply.</p>	<p>Retail: 10% coinsurance but not less than \$10 and not more than \$50 (1-31 day supply), deductible does not apply.</p> <p>10% coinsurance but not less than \$10 and not more than \$100 (32-90 day supply), deductible does not apply..</p>	<p><u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 90 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain <u>specialty drugs</u>, from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. If you use a non-<u>network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u>. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u>. 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 <u>copay</u> and/or <u>coinsurance</u> may be applied.</p>

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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)	
	Tier 2 – Your Mid-Range Cost Option	<p>Retail: 30% <u>coinsurance</u> but not less than \$30 and not more than \$100 (1-31 day supply), <u>deductible</u> does not apply.</p> <p>30% <u>coinsurance</u> but not less than \$30 and not more than \$200 (32-90 day supply), <u>deductible</u> does not apply.</p> <p>Mail-Order: 30% <u>coinsurance</u> but not less than \$30 and not more than \$200 (90 day supply), <u>deductible</u> does not apply.</p> <p>Specialty: 30% <u>coinsurance</u> but not less than \$60 and not more than \$200 (1-30 day supply), <u>deductible</u> does not apply.</p>	<p>Retail: 30% coinsurance but not less than \$30 and not more than \$100 (1-31 day supply), deductible does not apply.</p> <p>30% coinsurance but not less than \$30 and not more than \$200 (32-90 day supply), deductible does not apply.</p>	
	Tier 3 – Your Mid-Range Cost Option	<p>Retail: 50% <u>coinsurance</u> but not less than \$60 and not more than \$150 (1-31 day supply), <u>deductible</u> does not apply.</p> <p>50% <u>coinsurance</u> but not less than \$60 and not more than \$300 (32-90</p>	<p>Retail: 50% coinsurance but not less than \$60 and not more than \$150 (1-31 day supply), deductible does not apply.</p> <p>50% coinsurance but not less than \$60 and not more than \$300 (32-90</p>	

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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)	
		day supply), <u>deductible</u> does not apply. Mail-Order: 50% <u>coinsurance</u> but not less than \$60 and not more than \$300 (90 day supply), <u>deductible</u> does not apply. Specialty: 50% <u>coinsurance</u> but not less than \$120 and not more than \$300 (1-30 day supply), <u>deductible</u> does not apply.	day supply), <u>deductible</u> does not apply.	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not Covered	None
	Physician/surgeon fees	10% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not Covered	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$200 <u>copay</u> per visit, then 10% <u>coinsurance</u> , <u>deductible</u> does not apply.	\$200 <u>copay</u> per visit, then 10% <u>coinsurance</u> , <u>deductible</u> does not apply.	None
	<u>Emergency medical transportation</u>	\$100 <u>copay</u> per transport, then 10% <u>coinsurance</u> , <u>deductible</u> does not apply.	\$100 <u>copay</u> per transport, then 10% <u>coinsurance</u> , <u>deductible</u> does not apply.	None

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [welcometouhc.com](http://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>Urgent care</u>	\$50 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$200 <u>copay</u> per admission, then 10% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not Covered	None
	Physician/surgeon fees	10% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not Covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	None
	Inpatient services	\$200 <u>copay</u> per admission, then 10% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not Covered	None
<b>If you are pregnant</b>	Office visits	No Charge	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.)
	Childbirth/delivery professional services	10% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not Covered	
	Childbirth/delivery facility services	\$200 <u>copay</u> per admission, then 10% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not Covered	None
<b>If you need help recovering or have</b>	<u>Home health care</u>	10% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not Covered	Limited to 60 visits per calendar year.

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)	
<b>other special health needs</b>	<u>Rehabilitation services</u>	All other therapies: \$40 <u>copay</u> per visit, <u>deductible</u> does not apply. Pulmonary & Cardiac: 10% <u>coinsurance</u> <u>deductible</u> does not apply.	Not Covered	Limits per calendar year: Physical: 45 visits; Occupational: 45 visits; Speech: 60 visits; Cardiac: unlimited visits Pulmonary: unlimited visits.
	<u>Habilitative services</u>	All other therapies: \$40 <u>copay</u> per visit, <u>deductible</u> does not apply. Pulmonary & Cardiac: 10% <u>coinsurance</u> <u>deductible</u> does not apply.	Not Covered	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	\$30 <u>copay</u> per admission, then 10% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not Covered	Limited to 80 days per calendar year (combined with inpatient rehabilitation).
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> <u>deductible</u> does not apply.	Not Covered	None
	<u>Hospice services</u>	10% <u>coinsurance</u> <u>deductible</u> does not apply.	Not Covered	None
<b>If your child needs dental or eye care</b>	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"><li>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Dental care</li><li>• Glasses</li></ul> | <ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when travelling outside - the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Private duty nursing</li><li>• Routine eye care</li><li>• Routine foot care – Except as covered for Diabetes</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>• Bariatric surgery</li></ul> | <ul style="list-style-type: none"><li>• Chiropractic (Manipulative care) – 20 visits per calendar year</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids</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: 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). 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: the Member Service number listed on the back of your ID card or [myuhc.com](http://myuhc.com).

Additionally, a consumer assistance program may help you file your appeal. Contact [dol.gov/ebsa/healthreform](http://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 1-866-633-2474.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2474.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-633-2474.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-866-633-2474 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2474.

Samoa (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2474.

Carolinian (Kapasal Falawasch): ngere aukke ghut allillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2474.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-633-2474.

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

