



Select Plus CDHP-HSA (CA Only)



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, visit www.welcometouhc.com or call 844-636-5296. 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 844-636-5296 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> : \$1,700.00 Individual / \$3,400.00 Family <u>Non-Network</u> : \$3,400.00 Individual / \$6,800.00 Family per calendar year.	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive Care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <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 <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network provider</u> *: \$3,400.00 Individual / \$6,800.00 Family For <u>out-of-network providers</u> *: \$6,800.00 Individual / \$13,600.00 Family per calendar year *Out-of-pockets cross-apply	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, penalties for failure to obtain <u>prior authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.myuhc.com or call 844-636-5296 for a list of network providers .	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 referral to see a specialist ?	No	You can see the specialist you choose without a referral .

 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	10% coinsurance	30% coinsurance	Virtual visit – In- network providers have a 10% coinsurance after deductible by a Designated Virtual Network Provider . No virtual visit coverage for out of network providers . If you receive services in addition to office visit, additional copays, deductibles , or coinsurance may apply.
	Specialist visit	10% coinsurance	30% coinsurance	If you receive services in addition to office visit, additional copays, deductibles , or coinsurance may apply.
	Preventive care/screening/immunization	No charge	30% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Prior Authorization required out of network for Sleep Studies for certain services or \$350.00 penalty applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com	Generic Drugs (Tier 1)	Retail: 10% <u>coinsurance</u> Mail Order: 10% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	Retail up to 30-day supply Mail Order / Maintenance Medications up to 90-day supply
	Preferred brand drugs (Tier 2)	Retail: 10% <u>coinsurance</u> Mail Order: 10% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	Retail up to 30-day supply Mail Order / Maintenance Medications up to 90-day supply
	Non-preferred brand drugs (Tier 3)	Retail: 10% <u>coinsurance</u> Mail Order: 10% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	Retail up to 30-day supply Mail Order / Maintenance Medications up to 90-day supply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Specialty drugs</u>	Covered at applicable drug tier	Retail: N/A Mail Order: N/A	You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by ESI. 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, 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 <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 copay and/or <u>coinsurance</u> may be applied. Prescription drug costs are subject to the annual deductible for out of network. Specialty limited up to 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> for out-of- <u>network providers</u> or \$350.00 penalty applies.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Urgent care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> required for <u>out-of-network provider</u> or \$350.00 penalty applies.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> for certain services or \$350.00 penalty applies. Intensive Behavioral Therapy (ABA) covered at 10% in- <u>network</u> and 30% after out-of- <u>network plan deductible</u> .
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> for inpatient facility or a \$350.00 penalty applies.
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> required for out-of- <u>network providers</u> for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or \$350.00 penalty applies. <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>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> for out-of- <u>network Home Health Care</u> for certain services (skilled nursing by RN or LPN) or \$350.00 penalty applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Cardiac 36 visits, Pulmonary 20 visits, Occupational, Speech and Physical therapy 60 visits each combined In and out of network. Limits waived with mental health diagnosis.
	<u>Habilitation services</u>	10% coinsurance	30% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 days combined In and out-of- <u>network</u> per calendar year. Limits waived with mental health diagnosis <u>Prior Authorization</u> required for out-of- <u>network providers</u> or \$350.00 penalty applies
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> for DME over \$1,000 per device (Purchase or cumulative rental) or \$350.00 penalty applies. Coverage includes 1 device/unit per type of DME (including repair/replacement) every 3 years.
	<u>Hospice services</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Prior Authorization</u> required for <u>out-of-network provider</u> before admission for an inpatient stay in a hospice facility or \$350.00 penalty applies.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Child routine vision exam is not covered.
	Children's glasses	Not covered	Not covered	Child glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Child dental check-up is not covered.

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.)

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| <ul style="list-style-type: none">• Adult routine vision exam (i.e. refraction)• Cosmetic Surgery• Dental Care (Adult) | <ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private-duty nursing• Routine foot care• Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none">• Acupuncture – 24 visits per calendar year• Bariatric Surgery | <ul style="list-style-type: none">• Chiropractic care (Manipulative Care) – 24 visits per calendar year. | <ul style="list-style-type: none">• Hearing aids-\$5,000 every 2 calendar years. |
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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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. 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: 844-636-5296 or visit www.welcometouhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.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 844-636-5296.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-636-5296.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 844-636-5296.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 844-636-5296 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-636-5296.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 844-636-5296.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 844-636-5296.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 844-636-5296.

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)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,700.00
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700.00
<u>Copayments</u>	\$0.00
<u>Coinsurance</u>	\$1,100.00
<u>What isn't covered</u>	
Limits or exclusions	\$60.00
The total Peg would pay is	\$2,860.00

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,700.00
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700.00
<u>Copayments</u>	\$0.00
<u>Coinsurance</u>	\$400.00
<u>What isn't covered</u>	
Limits or exclusions	\$20.00
The total Joe would pay is	\$2,120.00

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,700.00
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700.00
<u>Copayments</u>	\$0.00
<u>Coinsurance</u>	\$100.00
<u>What isn't covered</u>	
Limits or exclusions	\$0.00
The total Mia would pay is	\$1,800.00