



CDHP - HSA 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, 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 <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> 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> : \$1,600.00 Individual / \$3,200.00 Family <u>Non-Network</u> : \$3,200.00 Individual / \$6,400.00 Family per calendar year.	Generally, you must pay all of the costs from providers 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> and primary care services 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> *: \$3,200.00 Individual / \$6,400.00 Family For <u>out-of-network providers</u> *: \$6,400.00 Individual / \$12,800.00 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 pre-notification 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 https://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. Your employer will make an annual contribution to the HSA on your behalf that can be used to offset your deductible (or coinsurance) cost share. Contributions for 2024 are \$800 individual or \$1,600 family.

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 covered at 90% after deductible per visit. No virtual visit coverage for out of network . If you receive services in addition to office visit, additional copays, deductibles , or co-ins may apply.
	Specialist visit	10% coinsurance	30% coinsurance	None
	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. None
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Prior Authorization required non- network Sleep Studies or \$350 penalty applies.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	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)	
<p>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</p>	Generic Drugs (Tier 1)	Retail: 10% <u>coinsurance</u> Mail Order: 10% <u>coinsurance</u>	Retail: 30% coinsurance	Retail up to 30-day supply Mail Order / Maintenance Medication up to 90-day supply
	Preferred brand drugs (Tier 2)	Retail: 10% <u>coinsurance</u> Mail Order: 10% <u>coinsurance</u>	Retail: 30% coinsurance	Retail up to 30-day supply Mail Order / Maintenance Medication 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 Medication up to 90-day supply
	<u>Specialty drugs</u>	Covered at applicable drug tier	N/A	You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or you may be required to try a lower cost alternative before your medication is approved. If you use a non-network pharmacy, you may be responsible for the full cost of the medication. Certain preventive medications (including certain contraceptives) are covered at No Charge. Not all drugs are covered by your plan. Please visit the website listed to review the coverage. If a dispensed drug as 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. Specialty limited up to 30-day supply.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	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
	<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>Preauthorization</u> is required non-network for certain services or \$350 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>	Prior Authorization required non-network or there is a \$350.00 penalty. Neurobiological Disorders – Prior Authorization is also required for Benefits provided for Applied Behavioral Analysis (ABA)
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior Authorization required non-network or there is a \$350.00 penalty
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Routine Pre Natal is covered at no charge. Non-network Prior Authorization required for timeframes that exceed the standard or there is a \$350.00 penalty
	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	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 100 visits per calendar year. Prior Authorization required non-network or there is a \$350.00 penalty

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)	
other special health needs	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Cardiac 36 visits, Pulmonary 20 visits, calendar year combined in and out of <u>network</u>
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	See Rehabilitation services
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 days per calendar year combined In and Out of <u>network</u> per calendar year. Prior Authorization required non- <u>network</u> for Skilled Nursing or there is a \$350.00 penalty
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior Authorization required non- <u>network</u> DME devices that cost more than \$1,000.00 per device (Purchase or cumulative rental) or there is a \$350.00 penalty Covers 1 per type of DME (including repair/replacement) every 3 years.
	<u>Hospice services</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Prior Authorization required non- <u>network</u> or there is a \$350.00 penalty
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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"> • Adult routine vision exam (i.e. refraction) • Cosmetic Surgery • Dental Care (Adult) 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • 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• Hearing aids- \$2,500 per calendar year max | <ul style="list-style-type: none">• Routine foot care |
|---|---|---|

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 <https://uhc.welcometouhc.com/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.

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

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, kwijigo holne' 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 deductible	\$1600.00
■ <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>	\$1,600.00
<u>Copayments</u>	\$0.00
<u>Coinsurance</u>	\$1,100.00
<u>What isn't covered</u>	
Limits or exclusions	\$70.00
The total Peg would pay is	\$2,770.00

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall deductible	\$1600.00
■ <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>	\$800.00
<u>Copayments</u>	\$0.00
<u>Coinsurance</u>	\$30.00
<u>What isn't covered</u>	
Limits or exclusions	\$4,300.00
The total Joe would pay is	\$5,130.00

Mia's Simple Fracture

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

■ The <u>plan's</u> overall deductible	\$1600.00
■ <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>	\$1,600.00
<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	\$1,710.00

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>

Complaint forms are available at <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.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

Summary of (توجه: اگر زبان شما فارسی) Farsi (است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خالصه مزایا و پوشش) Benefits and Coverage, SBC (تماس بگیرید).

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CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (**Khmer**) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá júk'eh, bee ná'ahóót'i'. T'áá shqodí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá júk'ehgo béesh bee hane'í biká'ígíí bee hodílnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).