### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>Network: $2,000 *Individual / $4,000 Family Non-Network: $2,000 *Individual / $4,000 Family Per calendar year. Services listed below as &quot;No Charge&quot; do not apply to the deductible. *Doesn't apply if policy covers 2+ people.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> 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.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet <strong>deductibles</strong> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Is there an out-of-pocket limit on my expenses?</strong></td>
<td>Network: $3,000 *Individual / $6,000 Family Non-Network: $5,000 *Individual / $10,000 Family *Doesn’t apply if policy covers 2+ people.</td>
<td>The <strong>out-of-pocket limit</strong> 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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td><strong>Premium</strong>, balance-billed charges, health care this plan doesn’t cover, and penalties for failure to obtain pre-notification for services.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td><strong>Is there an overall annual limit on what the plan pays?</strong></td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td><strong>Does this plan use a network of providers?</strong></td>
<td>Yes. For a list of <strong>network providers</strong>, see <strong>myuhc.com</strong> or call 1-888-322-2646.</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, 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 <strong>provider</strong> for some services. Plans use the term in-network, <strong>preferred</strong>, or participating for <strong>providers</strong> in their <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td><strong>Do I need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the <strong>specialist</strong> you choose without permission from this plan.</td>
</tr>
<tr>
<td><strong>Are there services this plan doesn’t cover?</strong></td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-888-322-2646 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:** 01/01/2017 – 12/31/2017

**Plan Type:** PS1

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

<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>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>Virtual visits (Telehealth) – 10% co-ins after deductible per visit by a designated virtual network provider. No virtual coverage out-of-network.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>Cost share applies to manipulative (chiropractic) services only and is limited to 20 visits per calendar year. Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No Charge</td>
<td>30% co-ins after ded.</td>
<td>Includes preventive health services specified in the health care reform law.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT / PET scans, MRIs)</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 – Your Lowest-Cost Option</td>
<td>Retail: $15 copay after ded.</td>
<td>Not Covered</td>
<td>Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mail-Order: $37.50 copay after ded.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## HSA Choice Plus HDHP Plan

### Summary of Benefits and Coverage:

**Coverage Period:** 01/01/2017 – 12/31/2017

**Coverage for:** Employee & Family

**Plan Type:** PS1

### 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>Tier 2 – Your Midrange-Cost Option</td>
<td>Retail: $50 copay after ded. Mail-Order: $125 copay after ded.</td>
<td>Not Covered</td>
<td>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 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.</td>
</tr>
<tr>
<td>Tier 3 – Your Highest-Cost Option</td>
<td>Retail: $100 copay after ded. Mail Order: $250 copay after ded.</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Tier 4 – Additional High-Cost Options</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td></td>
</tr>
</tbody>
</table>

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### If you have outpatient surgery

| Facility fee (e.g., ambulatory surgery center) | 10% co-ins after ded. | 30% co-ins after ded. | None |
| Physician / surgeon fees | 10% co-ins after ded. | 30% co-ins after ded. | None |

### If you need immediate medical attention

| Emergency room services | 10% co-ins after ded. | *10% co-ins after ded. | *Network deductible applies |
| Emergency medical transportation | 10% co-ins after ded. | *10% co-ins after ded. | *Network deductible applies |
| Urgent care | 10% co-ins after ded. | 30% co-ins after ded. | None |

### If you have a hospital stay

| Facility fee (e.g., hospital room) | 10% co-ins after ded. | 30% co-ins after ded. | Pre-notification is required non-network or benefit reduces to 50% of eligible expenses. |
| Physician / surgeon fees | 10% co-ins after ded. | 30% co-ins after ded. | None |

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More information about [prescription drug coverage](https://myuhc.com) is available at myuhc.com
## Summary of Benefits and Coverage

**Coverage for:** Employee & Family  
**Plan Type:** PS1

### Coverage Period:
01/01/2017 – 12/31/2017

### 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 have mental health, behavioral health, or substance abuse needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental / Behavioral health outpatient services</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>Partial hospitalization/intensive outpatient treatment: 10% co-ins after ded. Pre-notification is required non-network for certain services or benefit reduces to 50% of eligible expenses.</td>
</tr>
<tr>
<td>Mental / Behavioral health inpatient services</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.</td>
</tr>
<tr>
<td>Substance use disorder outpatient services</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>Partial hospitalization/intensive outpatient treatment: 10% co-ins after ded. Pre-notification is required non-network for certain services or benefit reduces to 50% of eligible expenses.</td>
</tr>
<tr>
<td>Substance use disorder inpatient services</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal and postnatal care</td>
<td>No Charge</td>
<td>30% 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>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>Inpatient pre-notification may apply.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>Limited to 90 visits per calendar year. Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>Limits per calendar year: 90 combined visits of physical, speech, occupational therapies; Cardiac – 36 visits; pulmonary – 20 visits. Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.</td>
</tr>
<tr>
<td>Habilitative services</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>Limits are combined with Rehabilitation Services limits listed above.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>Limited to 30 days per calendar year. (combined with inpatient rehabilitation). Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.</td>
</tr>
</tbody>
</table>
# HSA Choice Plus HDHP Plan

**Coverage Period:** 01/01/2017 – 12/31/2017

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

**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>Durable medical equipment</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>Pre-notification is required non-network for DME over $500 or no coverage. Covers 1 per type of DME (including repair/replacement) every 3 years.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>10% co-ins after ded.</td>
<td>30% co-ins after ded.</td>
<td>Inpatient pre-notification is required for non-network or benefit reduces to 50% of eligible expenses.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</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

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

### Other Covered Services

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
HSA Choice Plus HDHP Plan  
Coverage Period: 01/01/2017 – 12/31/2017

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

Coverage for: Employee & Family

Plan Type: PS1

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:
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-322-2646.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-322-2646.
Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwiijgo holne' 1-888-322-2646.

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

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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.

**Having a baby** (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,920
- **Patient pays:** $2,620

**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: $2,000
- Copays: $20
- Coinsurance: $400
- Limits or exclusions: $200

**Total:** $2,620

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,330
- **Patient pays:** $3,070

**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: $2,000
- Copays: $1,000
- Coinsurance: $30
- Limits or exclusions: $40

**Total:** $3,070
## 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>
<th>Does the Coverage Example predict my own care needs?</th>
<th>Are there other costs I should consider when comparing plans?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Costs don’t include <strong>premiums</strong>.</td>
<td>For each treatment situation, the Coverage Example helps you see how <strong>deductibles</strong>, <strong>copayments</strong>, and <strong>coinsurance</strong> 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>✓ <strong>Yes.</strong> 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.</td>
<td>✗ <strong>No.</strong> 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.</td>
<td>✓ <strong>Yes.</strong> 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 <strong>copayments</strong>, <strong>deductibles</strong>, and <strong>coinsurance</strong>. 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.</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>
<td></td>
<td></td>
</tr>
<tr>
<td>• The patient’s condition was not an excluded or preexisting condition.</td>
<td></td>
<td></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>
<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>
<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>
<td></td>
<td></td>
</tr>
<tr>
<td>• The patient received all care from in-network <strong>providers</strong>. If the patient had received care from out-of-network <strong>providers</strong>, costs would have been higher.</td>
<td></td>
<td></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>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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