





## Choice Plus Copay



 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 <https://www.myuhc.com/> or call 1-844-298-8929. 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 1-844-298-8929 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<u>Network</u> *: \$750.00 Individual / \$1,500.00 Family. <u>Non-Network</u> *: \$3,000.00 Individual / \$6,000.00 Family per calendar year. * <u>Deductibles</u> cross-apply.	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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive Care</u> and primary care services with <u>copay</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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	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.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For <u>network provider</u> *: \$6,000.00 Individual / \$12,000.00. Family For <u>out-of-network providers</u> *: \$12,000.00 Individual / \$24,000.00 Family per calendar year * <u>Out-of-pockets</u> 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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 <b>network provider</b> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-844-298-8929 for a list of <b>network providers</b> . See <a href="https://www.Express-Scripts.com/BrownBrownInc">https://www.Express-Scripts.com/BrownBrownInc</a> for a list of <b>network pharmacy providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No	You can see the <b>specialist</b> you choose without a <b>referral</b> .

 All **coinsurance** costs shown in this chart are after your **deductible** has been met.

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)	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness.	\$25.00 <b>copay</b> /visit. (Mental/Behavioral Health and Substance Abuse – please see below)	40% <b>coinsurance</b>	<b>Copays</b> apply for provider's telemedicine or virtual visits except, \$0 <b>copay</b> by a Designated Virtual <b>Network Provider</b> . No Designated Virtual Provider visit coverage for out of <b>network</b> . If you receive services in addition to office visit, additional copays, <b>deductibles</b> , or <b>coinsurance</b> may apply.
	<b>Specialist</b> visit	\$50.00 <b>copay</b> /visit	40% <b>coinsurance</b>	None
	<b>Preventive care/screening/immunization</b>	No charge, <b>deductible</b> does not apply	40% <b>coinsurance</b>	You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are <b>preventive</b> . Then check what your <b>plan</b> will pay for. \$750.00 paid maximum out of <b>network</b> per calendar year. No maximum in <b>network</b> .
If you have a test	<b>Diagnostic test</b> (x-ray, blood work)	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Prior Authorization required non- <b>network</b> for Sleep Studies.

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)	
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b> <b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.Express-Scripts.com/BrownBrownInc">www.Express-Scripts.com/BrownBrownInc</a></b>	Generic Drugs (Tier 1)	Retail: \$15 <u>copay</u> Mail Order: \$45 <u>copay</u>	Retail: Not covered	Covers up to a 30-day retail supply; up to 90-day home delivery. Mandatory generic: You are responsible for the Tier 3 <u>copay</u> plus cost difference between the generic and brand medication when generic equivalent is available but not filled. Step therapy program applies.
	Preferred brand drugs (Tier 2)	Retail: \$50 <u>copay</u> Mail Order: \$150 <u>copay</u>	Retail: Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: \$90 <u>copay</u> Mail Order: \$270 <u>copay</u>	Retail: Not covered	
	Specialty drugs (Tier 4)	Retail: \$200 <u>copay</u> Mail Order: \$600 <u>copay</u>	Retail: Not covered Mail Order: N/A	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Mandatory Second Opinion is required for certain surgeries or \$750 <u>copay</u> and applicable <u>coinsurance</u> and <u>deductible</u> applies.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$400.00 <u>copay</u> /visit	\$400.00 <u>copay</u> /visit	<u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
	<u>Urgent care</u>	\$40.00 <u>copay</u> /visit	40% <u>coinsurance</u>	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Out-of-network: \$250 <u>copay</u> applies in addition to calendar year <u>deductible</u> and applicable <u>coinsurance</u> . Prior Authorization required out-of-network or \$1,000.00 penalty applies.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge /Office Visit All other services: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Cognitive Behavioral Therapy provided by AbleTo is covered at 100% no cost share for the initial consultation and ongoing therapeutic treatments. AbleTo is a contracted <u>provider</u> for Optum Behavioral services specifically for Cognitive Behavioral Therapy. Prior Authorization for certain outpatient services - required non- <u>network</u> . Prior Authorization is also required for Benefits provided for Applied Behavioral Analysis (ABA).
	Inpatient services	Platinum Preferred <u>Network</u> Substance Abuse Provider: deductible and <u>coinsurance</u> waived Other In- <u>Network Provider</u> : 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior Authorization required non- <u>network</u> or \$1,000.00 penalty.
<b>If you are pregnant</b>	Office visits	\$25.00 <u>copay</u> /initial visit only	40% <u>coinsurance</u>	Prior Authorization required non- <u>network</u> Inpatient stays that exceed normal 48 hours for vaginal delivery or 96 hours for cesarean or \$1,000.00 penalty. Routine pre-natal care is covered at no charge.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior Authorization required non- <u>network</u> for <u>Home Health Care</u> and Private Duty Nursing. 60 visits per calendar year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.

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>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior Authorization required non- <u>network</u> for Skilled Nursing or Private Duty Nursing. 60 days per calendar year in <u>network</u> and out of <u>network</u> combined.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior Authorization required non- <u>network</u> for DME devices.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior Authorization required non- <u>network</u> for Hospice In-patient Only or \$1,000.00 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Adult routine vision exam (i.e. refraction)</li> <li>• Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Dental Care (Adult)</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Fertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</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: 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/](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: 1-844-298-8929 or visit <https://www.myuhc.com/> or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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 1-844-298-8929.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-298-8929.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-298-8929.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-298-8929.

—————*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)

■ <u>The plan's overall deductible</u>	\$750.00
■ <u>Specialist copayment</u>	\$50.00
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$750.00
<u>Copayments</u>	\$50.00
<u>Coinsurance</u>	\$2,380.00
<u>What isn't covered</u>	
Limits or exclusions	\$0.00
<b>The total Peg would pay is</b>	<b>\$3,180.00</b>

### Managing Joe's type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$750.00
■ <u>Specialist copayment</u>	\$50.00
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$750.00
<u>Copayments</u>	\$200.00
<u>Coinsurance</u>	\$0.00
<u>What isn't covered</u>	
Limits or exclusions	\$0.00
<b>The total Joe would pay is</b>	<b>\$950.00</b>

### Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$750.00
■ <u>Specialist copayment</u>	\$50.00
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$750.00
<u>Copayments</u>	\$400.00
<u>Coinsurance</u>	\$330.00
<u>What isn't covered</u>	
Limits or exclusions	\$10.00
<b>The total Mia would pay is</b>	<b>\$1,490.00</b>

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](mailto: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.

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