




Choice+ HSA Plan - CA



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.ingrambenefits.com or call 1-800-876-7266. 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 1-866-204-3120 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network</u> : \$1,700 Individual / \$3,400 Family <u>Non-Network</u> : \$2,600 Individual / \$5,200 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> 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</u> providers: \$3,500 Individual / \$7,000 Family For out-of- <u>network</u> providers: \$7,000 Individual / \$14,000 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, 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 <u>network provider</u>?	Yes. This plan uses Network Select Plus. See www.myuhc.com or call 1-866-204-3120 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> 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
		<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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Virtual Visit – <u>In-network</u> 0% <u>coinsurance</u> after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . No virtual visit coverage for out of <u>network</u> (add when applicable). If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or co ins may apply.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or co ins may apply.
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> for Sleep Studies or benefit reduces by \$500 penalty.

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)	20% <u>coinsurance</u>	40% <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.caremark.com	Generic Drugs (Tier 1)	Retail: 20% <u>coinsurance</u> Mail Order: 20% <u>coinsurance</u>	Not Covered	30-day retail supply; 90-day mail order supply. To verify the coverage of a medication please call customer care at 1-800-503-3241, visit www.caremark.com , or download CVS Caremark's mobile app. Maintenance medications are available for a 90-day supply at either CVS retail pharmacies, CVS pharmacies within Target, or through mail order.
	Preferred brand drugs (Tier 2)	Retail: 20% <u>coinsurance</u> Mail Order: 20% <u>coinsurance</u>	Not Covered	
	Non-preferred brand drugs (Tier 3)	Retail: 20% <u>coinsurance</u> Mail Order: 20% <u>coinsurance</u>	Not Covered	

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> (Tier 4)	Retail: 20% <u>coinsurance</u> Mail Order: Not covered	Not Covered	<p>If applicable, when a brand medication is chosen by you even though a generic equivalent is available under the plan, you will pay a higher copay/coinsurance as well as paying the difference in cost between the brand and generic medication.</p> <p>Medication/Prescription Drugs classified as “Specialty or Limited Distribution” can be obtained through CVS Specialty Pharmacy. Please visit www.cvsspecialty.com or call 1-800-237-2767. These medications will be shipped to your home or local CVS pharmacy for pick up.</p> <p>Certain brand name drugs are subject to step therapy requirements.</p> <p>You can receive up to a 30-day supply at your local participating pharmacy or 90-day supply by mail or at a CVS pharmacy.</p> <p>Out-of-network prescriptions: Member pays full cost and files a paper claim for reimbursement. Member will be reimbursed the discounted cost of the drug, minus the applicable member cost share.</p> <p>Specialty drugs are dispensed exclusively through CVS/Caremark’s Specialty Pharmacy.</p>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network or benefit reduces by \$500 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network or benefit reduces by \$500 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required for certain services out-of-network or benefit reduces by \$500 penalty.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for inpatient facility or benefit reduces by \$500 penalty.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for Inpatient stays that exceed normal 48 hours for natural delivery or 96 hours for cesarean or benefit reduces by \$500 penalty. <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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

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 need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN) or benefit reduces by \$500 penalty. 60 visit limit per calendar year (combined in-network and out-of-network) applies to physical, speech, occupational therapy provided in the home.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Cardiac Rehabilitation - 36 visit limit; Pulmonary Rehabilitation - 36 visit limit; Occupational Therapy - 30 visit limit; Physical Therapy - 30 visit limit and \$15 copay per visit (in-network) after deductible. All other therapies: 20% coinsurance after deductible (in-network); Speech Therapy - 30 visit limit. Note: All visits are per calendar year.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Habilitation Services</u> are provided, and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network by \$500 penalty. 100 day limit applies per calendar year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for DME devices that cost more than \$1,000 per device or benefit reduces by \$500 penalty.

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>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> before admission for an inpatient stay in a hospice facility or benefit reduces by \$500 penalty.
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 <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"> • Acupuncture • Adult routine vision exam (i.e. refraction) • Cosmetic Surgery • Dental Care (Adult) 	<ul style="list-style-type: none"> • <u>Habilitation Services</u> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Weight loss programs
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"> • Bariatric Surgery – 1 surgery per lifetime • Routine foot care 	<ul style="list-style-type: none"> • Chiropractic care – 30 visits per calendar year 	<ul style="list-style-type: none"> • Hearing aids – 1 per hearing impaired ear every 36 months. Covered only for members under the age of 18.

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: 1-866-204-3120 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? No

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 1-866-204-3120.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-204-3120.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-204-3120.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deitsch, ruf 1-866-204-3120 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-204-3120.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-204-3120.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-204-3120.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-204-3120.

—————*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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ <u>The plan's overall deductible</u>	\$1,700	■ <u>The plan's overall deductible</u>	\$1,700	■ <u>The plan's overall deductible</u>	\$1,700
■ <u>Specialist coinsurance</u>	20%	■ <u>Specialist coinsurance</u>	20%	■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%	■ <u>Hospital (facility) coinsurance</u>	20%	■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%	■ <u>Other coinsurance</u>	20%	■ <u>Other coinsurance</u>	20%
<p>This EXAMPLE event includes services like: <u>Specialist office visits (pre-natal care)</u> <u>Childbirth/Delivery Professional Services</u> <u>Childbirth/Delivery Facility Services</u> <u>Diagnostic tests (ultrasounds and blood work)</u> <u>Specialist visit (anesthesia)</u></p>		<p>This EXAMPLE event includes services like: <u>Primary care physician office visits (including disease education)</u> <u>Diagnostic tests (blood work)</u> <u>Prescription drugs</u> <u>Durable medical equipment (glucose meter)</u></p>		<p>This EXAMPLE event includes services like: <u>Emergency room care (including medical supplies)</u> <u>Diagnostic test (x-ray)</u> <u>Durable medical equipment (crutches)</u> <u>Rehabilitation services (physical therapy)</u></p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,700	<u>Deductibles</u>	\$1,100	<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0	<u>Copayments</u>	\$0	<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,800	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$100
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$70	Limits or exclusions	\$4,300	Limits or exclusions	\$10
The total Peg would pay is	\$3,570	The total Joe would pay is	\$5,400	The total Mia would pay is	\$1,810