



## Silver 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.myuhc.com](http://www.myuhc.com) or call 803-957-7367. 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](http://www.healthcare.gov/sbc-glossary) or call 855-819-0925 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<a href="#">Network</a> : \$3,000 Individual / \$6,000 Family Non- <a href="#">Network</a> : \$6,000 Individual / \$12,000 Family per calendar year.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your deductible?	Yes. <a href="#">Preventive Care</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other deductibles for specific services?	No, there are no other <a href="#">deductibles</a> .	You don't have to meet <a href="#">deductibles</a> for specific services, but see the chart starting on page 2 for other costs for services this <a href="#">plan</a> covers.
What is the <a href="#">out-of-pocket limit</a> for this plan?	For <a href="#">network provider</a> : \$7,000 Individual / \$9,200 Family For out-of- <a href="#">network providers</a> : \$15,000 Individual / \$30,000 Family per calendar year	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limits</a> must be met.
What is not included in the out-of-pocket limit?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, penalties for failure to obtain <a href="#">prior authorization</a> for services.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket</a> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 855-819-0925 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 provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Virtual visit - In <u>network</u> 20% <u>coinsurance</u> after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or <u>coinsurance</u> may apply. No virtual visit coverage out of <u>network</u> .
	Specialist 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-insurance may apply.
	Preventive care/ <u>screening</u> /immunization	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 certain services

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>	<u>Prior Authorization</u> required out-of-network.
<p>If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.welcometouhc.com">www.welcometouhc.com</a></p>	Generic Drugs (Tier 1)	<p><b>Deductible Applies</b> Retail: \$15 <u>copay</u> Mail Order: \$37.50 <u>copay</u></p>	Retail: Not covered	<p><b>Deductible Applies</b> \$15/\$30/\$37.50 for 1-31; 32-60; 61–90-day supply, respectively Certain drugs may require a Pre-Authorization. <u>Network</u>: Certain preventive medications (including certain contraceptives) are covered at No charge. \$10,000 individual annual infertility maximum.</p>
	Preferred brand drugs (Tier 2)	<p><b>Deductible Applies</b> Retail: \$30 <u>copay</u> Mail Order: \$75 <u>copay</u></p>	Retail: Not covered	<p><b>Deductible Applies</b> \$30/\$60/\$75 for 1-31; 32-60; 61–90-day supply, respectively Certain drugs may require a Pre-Authorization. <u>Network</u>: Certain preventive medications (including certain contraceptives) are covered at No charge. \$10,000 individual annual infertility maximum.</p>
	Non-preferred brand drugs (Tier 3)	<p><b>Deductible Applies</b> Retail: \$50 <u>copay</u> Mail Order: \$125 <u>copay</u></p>	Retail: Not covered	<p><b>Deductible Applies</b> \$50/\$100/\$125 for 1-31; 32-60; 61–90-day supply, respectively Certain drugs may require a Pre-Authorization. <u>Network</u>: Certain preventive medications (including certain contraceptives) are covered at No charge. \$10,000 individual annual infertility maximum.</p>

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)	
	Specialty drugs (Tier 4)	<b>Deductible Applies</b> Retail: N/A Mail Order: \$15 <u>copay</u>	Retail: Not covered	<b>Deductible Applies</b> Generic \$15 <u>copay</u> ; Preferred Brand \$ 30 and Non-Preferred Brand \$50 Drugs must be obtained from Optum <u>Specialty drug</u> . There is a 30-day supply limit on all <u>specialty drugs</u> . \$10,000 individual annual infertility maximum.
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- <u>network</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<a href="#">Urgent care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 Confinement <u>Deductible 20% coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> .
	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- <u>network</u> . EAP managed by TELUS Health. EAP benefit is 6 sessions per EAP Service/category per calendar year.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> required out-of- <u>network</u> for inpatient facility.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery professional 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)	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean. <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).
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN).
	<a href="#">Rehabilitation services</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Occupational, Cognitive, Physical, and Pulmonary Therapies are 20 visits each. Speech Therapy and Cardiac rehab is unlimited per calendar year. All visits are combined for In- <u>Network</u> and Out -of- <u>Network</u> .
	<a href="#">Habilitation</a> services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Habilitation Services are provided, and limits are combined with Rehabilitation Services above.
	<a href="#">Skilled nursing care</a>	\$0 Confinement <u>Deductible</u> 20% <u>coinsurance</u>	\$0 Confinement <u>Deductible</u> 40% <u>coinsurance</u>	Limited to 60 days per calendar year. Combined In- <u>Network</u> and Out-of- <u>Network</u> . <u>Prior Authorization</u> required out-of- <u>network</u> .
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> .

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)	
	<a href="#">Hospice services</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network.
If your child needs dental or eye care	Children's eye exam	20% <u>coinsurance</u>	Not covered	1 visit every 2 calendar years - <u>Network</u> only
	Children's glasses	Not covered	Not covered	Child glasses not covered.
	Children's dental check-up	Not covered	Not covered	Child dental check-up not covered.

**Excluded Services & Other Covered Services:**

Services Your Plan Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> <li>• Acupuncture - 25 visits per calendar year</li> <li>• Adult routine vision exam (i.e. refraction) - limited to 1 every 2 calendar years</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care - 20 visits per calendar year</li> <li>• Hearing aids - limited to \$2,000 and 1 every 36 months</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Weight loss programs</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: 855-819-0925 or visit [www.welcometouhc.com](http://www.welcometouhc.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 855-819-0925 .

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 855-819-0925 .

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 855-819-0925 .

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 855-819-0925 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-819-0925 .

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 855-819-0925 .

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 855-819-0925 .

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 855-819-0925 .

*—————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 plan's overall deductible	\$3,000
■ Specialist <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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>	\$3,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,970</b>

### Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$3,000
■ Specialist <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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>	\$3,000
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,500</b>

### Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,000
■ Specialist <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>