



HSACHoice Plus Plan

Coverage for: Family Plan Type: PS

The Summary of Benefits and Coverage (SBC) document will help you choose a 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 (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 plan, call 1-866-314-0335 or visit welcometouhc.com. For general definitions of common terms, allowable amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/glossary or call

Common Medical Event	Services You May Receive	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)	

* For more information about limitations and exceptions, please refer to the policy document welcometouhc.com

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>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility. <u>benefit reduces to 50% allowed amount</u>
If your child needs dental or eye care	& K L O G U H Q ¶ V	20% <u>coinsurance</u>	Not Covered	Limited to 1 exam every 2 years. No coverage <u>out-of-network</u>

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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 ~~complain~~ ^{report} to the Civil Rights Coordinator.

Online: _____

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~~ ^{out} ~~it~~ ^{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 ~~file~~ ^{file} number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

आपके लिए नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits) ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता

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