



Choice 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 other would share the cost for covered health care services. NOTE: Information about the cost of this (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, call 1-800-824-9259, or visit [welcometouhc.com](http://welcometouhc.com). For general definitions of common terms, allow us to email you a glossary of insurance billing.



Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		SLUCare & SSM Network Provider (You will pay the least)	Other Participating Provider Network Provider (You may pay more)	Out-of-Network Provider (You will pay the most)	
	Tier 4 ± Your Highest Cost Option	20% Coinsurance \$200 Max	N/A		
If you have outpatient surgery					

\* For more information about limitations and exceptions, please refer to the policy document [welcometouhc.com](http://welcometouhc.com)



**Excluded Services & Other Covered Services:**

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of excluded services)		
Acupuncture Cosmetic surgery Dental care Glasses	Hearing aids Infertility treatment Long-term care Non-emergency care when travelling outside the U.S.	Prescription drugs Private duty nursing Routine eye care Routine foot care Diabetes Weight loss programs
2 WKHU & RYHUHG 6 HU YLFHV / LPLWDWLRQV PD\ DSSO\ W Plan Document) V HU YLFHV 7 KLV		
Bariatric surgery	Chiropractic (Manipulative care) visits per calendar year	

**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 the U.S. Department of Labor, Employee Benefits Security Administration is 866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or the U.S. Department of Health and Human Services is 877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you including individual insurance coverage through the Health Insurance Marketplace. For more information about Marketplace visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your employer or a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the plan documents you will receive for that medical plan. Your plan documents also provide complete information on how to submit a claim appeal or grievance for any reason to your plan. For more information about your rights, this notice, or assistance contact the Member Service number listed on the back of your ID card or the Employee Benefits Security Administration at 866-444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

Additionally, a consumer assistance program may help you file your appeal. Contact [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage?** Yes?

Minimum Essential Coverage generally includes plans, health insurance available through Marketplace or other individual market policies, Medicare, Medicaid, TRICARE, and certain other government programs. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

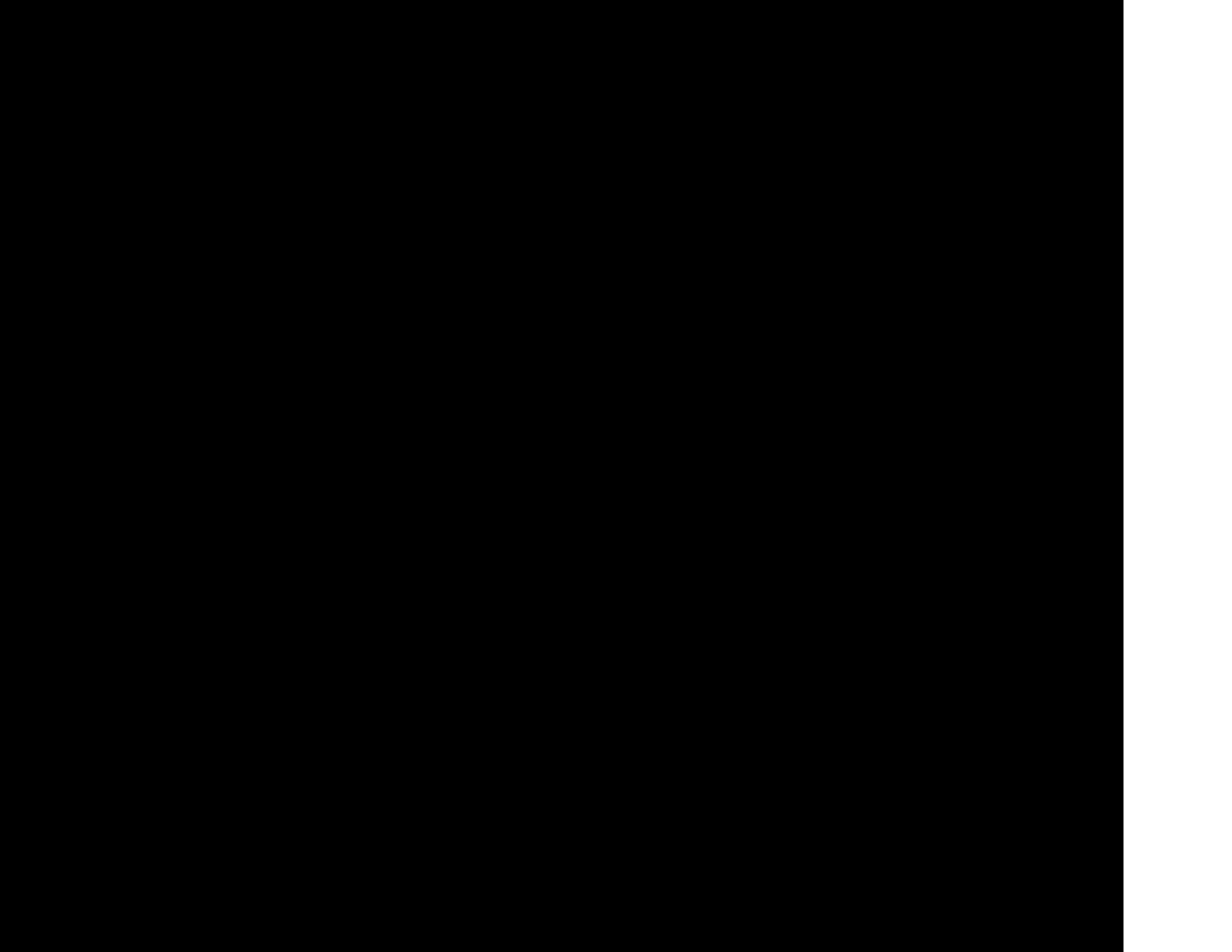
**Does this plan meet the Minimum Value Standards?** Yes?

If you plan G R H V Q Minimum Value Standards

\* For more information about limitations and exceptions, please refer to your plan document at [welcometouhc.com](http://welcometouhc.com)

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







알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of

Benefits and Guarantees)를 참조하십시오. [언어 지원 서비스](#)에 대한 자세한 내용은 [언어 지원 서비스](#) 페이지를 참조하십시오.

본 혜택 및 보장 요약서(Summary of Benefits and Guarantees)는 [언어 지원 서비스](#)에 대한 자세한 내용은 [언어 지원 서비스](#) 페이지를 참조하십시오.

