# Clark County ESC Choice Plus HDHP Plan

Coverage Period: 01/01/2025 – 12/31/2025

Coverage for: Family | Plan Type: PS1

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 1-866-633-2446.or visit welcometouhc.com. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary/</u> or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:			
What is the overall deductible?	Network: \$2,500 Individual / \$5,000 Family Non-Network: \$5,000 Individual / \$10,000 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. Deductible resets January 1. Deductible is non-embedded.			
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and categories with a <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 annual <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 services at <u>www.healthcare.gov/coverage/preventive-care-benefits/.</u>			
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.			
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Network: \$2,500 Individual / \$5,000 Family Non-Network: \$5,000 Individual / \$10,000 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> , the overall family <u>out-of-pocket limit</u> must be 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 and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.			
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>myuhc.com</u> or call <b>1-866-633-2446</b> 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 out-of- <u>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 specialist you choose without a referral.			



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

		What You	ı Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
16	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Virtual visits (Telehealth) - 0% <u>coinsurance</u> by a Designated Virtual <u>Network Provider</u> . No virtual coverage out-of- <u>network</u>	
If you visit a health care provider's office	Specialist visit	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None	
or clinic	Preventive care/screening/ immunization	No Charge	30% <u>coinsurance</u> after \$500 deductible	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required out-of-network for certain services or benefit reduces to 50% of allowed amount.	
ii you nave a test	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required out-of-network or benefit reduces to 50% of <u>allowed amount</u> .	
	Tier 1 – Your Lowest Cost Option	Retail: 0% coinsurance Mail-Order: 0% coinsurance	Not covered	Provider means pharmacy for purposes of this section.  Retail: Up to a 30-day supply	
If you need drugs to treat your illness or condition	Tier 2 – Your Mid-Range Cost Option	Retail: 0% coinsurance Mail-Order: 0% coinsurance	Not covered	Mail-Order: Up to a 90-day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Notification requirement or may result	
More information about prescription drug coverage is available at www.caremark.com	Tier 3 – Your Mid-Range Cost Option	Retail: 0% coinsurance Mail-Order: 0% coinsurance	Not covered	in a higher cost. If you use a non-network Pharmacy, you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain	
	Tier 4 – Your Highest Cost Option	Retail: 0% coinsurance Mail-Order: Not covered	Not covered	prescribed drugs. Tier 1 Contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required out-of-network for certain services or benefit reduces to 50% of allowed amount.	

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>welcometouhc.com</u>.

		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None	
If you need	Emergency room care	0% <u>coinsurance</u>	*0% <u>coinsurance</u>	*Network deductible applies	
immediate medical attention	Emergency medical transportation	0% <u>coinsurance</u>	*0% <u>coinsurance</u>	*Network deductible applies	
atterition	<u>Urgent care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None	
If you have a hospital	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required out-of-network or benefit reduces to 50% of allowed amount.	
stay	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None	
If you need mental health, behavioral health, or substance	Outpatient services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Network Partial hospitalization/intensive outpatient treatment: 0% coinsurance Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.	
abuse services	Inpatient services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required out-of- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .	
	Office visits	No Charge	30% <u>coinsurance</u>	Cost sharing does not apply for preventive services.	
If you are pregnant	Childbirth/delivery professional services	0% <u>coinsurance</u>	30% <u>coinsurance</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 facility services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Inpatient preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.	
If you need help	Home health care	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 visits per calendar year. <u>Preauthorization</u> is required out-of- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .	
If you need help recovering or have other special health needs	Rehabilitation services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Any combination of outpatient rehabilitation services is limited to 50 visits per calendar year. <u>Preauthorization</u> required out-of- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .	
	<u>Habilitative services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Services are provided under and limits are combined with Rehabilitation Services above.	

 $<sup>^{\</sup>star}$  For more information about limitations and exceptions, see the  $\underline{\text{plan}}$  or policy document at  $\underline{\text{welcometouhc.com}}.$ 

	Services You May Need	What You Will Pay		
Common Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				<u>Preauthorization</u> required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Skilled nursing care	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Skilled Nursing is limited to 120 days per calendar year. Inpatient rehabilitation limited to 300 days.  Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Durable medical equipment	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Covers 1 per type of DME (including repair/replacement) every 3 years.  Preauthorization is required out-of-network for DME over \$1,000 or benefit reduces to 50% of allowed amount.
	Hospice services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
	Children's eye exam	0% <u>coinsurance</u>	Not Covered	Limited to 1 exam every year.  No coverage out-of-network.
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
·	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

### **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 any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Glasses

- Infertility treatment
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Prescription drugs
- Private duty nursing
- Routine foot care Except as covered for Diabetes
- Weight loss programs

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>welcometouhc.com</u>.

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic (Manipulative care) 50 visits per calendar year combined with Rehabilitation services
- Hearing aids \$2,500 per calendar year
- Routine eye care (adult) 1 exam per 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 those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <a href="https://www.dol.gov/ebsa">www.dol.gov/ebsa</a>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <a href="https://www.cciio.cms.gov">www.cciio.cms.gov</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance <a href="https://www.dol.gov/ebsa">Marketplace</a>. For more information about the <a href="https://www.dol.gov/ebsa">Marketplace</a>, visit <a href="https://www.delthCare.gov">www.delthCare.gov</a> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or <u>myuhc.com</u>.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

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

If you don't have <u>Minimum Essential Coverage</u> for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

#### 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 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

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

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>welcometouhc.com</u>.

## **About these Coverage Examples:**



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in- <u>network</u> pre-natal care and a hospital delivery)		Managing Joe's type 2 Diak (a year of routine in- <u>network</u> care of controlled condition)		Mia's Simple Fracture (in- <u>network</u> emergency room visit and follow up care)			
	<ul> <li>The plan's overall deductible</li> <li>Specialist coinsurance</li> <li>Hospital (facility) coinsurance</li> <li>Other coinsurance</li> </ul>	\$2,500 0% 0% 0%	<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> <li><u>Specialist coinsurance</u></li> <li>Hospital (facility) <u>coinsurance</u></li> <li>Other <u>coinsurance</u></li> </ul>	\$2,500 0% 0% 0%	<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> <li><u>Specialist coinsurance</u></li> <li>Hospital (facility) <u>coinsurance</u></li> <li>Other <u>coinsurance</u></li> </ul>	\$2,500 0% 0% 0%	
	This EXAMPLE event includes services Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood w Specialist visit (anesthesia)		This EXAMPLE event includes service: Primary care physician office visits (included education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose met	ding disease	This EXAMPLE event includes services like: Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)		
	Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900	
In this example, Peg would pay:			In this example, Joe would pay:		In this example, Mia would pay:		
Cost Sharing  Deductibles \$2,500		Cost Sharing Deductibles \$2,500		Cost Sharing  Deductibles	\$1,900		
	<u>Deductibles</u>	\$2,500		\$2,500		\$1,700	
	<u>Coincurance</u>	·	<u>Coincurance</u>	\$0	<u>Copayments</u>	\$0	
Coinsurance \$0		\$0	Coinsurance \$0  What isn't covered		Coinsurance \$0  What isn't covered		
What isn't covered Limits or exclusions \$60		\$60	Limits or exclusions \$55		Limits or exclusions	\$0	
	The total Peg would pay is	\$2,560			The total Mia would pay is	\$1,900	
	The total reg would pay is	<b>ΦΖ,300</b>	The total Joe would pay is	\$2,555	The total wha would pay 15	\$1,700	

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

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 <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a>.

**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.