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, call 1-877-856-2429 or visit uhc.com/aca-sample-policy. 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 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$3,600** Individual / **$7,200** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$8,000** Individual / **$16,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See uhc.com/xmadocfind2024 or call **1-877-856-2429** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. An electronic referral is required to see a Network Specialist	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (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	$60 copay per visit	Not Covered	Virtual visits – 0% coinsurance by a Designated Virtual Network Provider. *Cost share applies to any other Telehealth service based on provider type. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	$90 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Testing: $55 copay per service X-Ray/Diagnostic: $135 copay per service	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$750 copay per service	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at uhc.com/xmadruglist3tier2024	Tier 1 – Your Lowest Cost Option	$30 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31-day supply. Mail-Order: Up to a 90-day supply at 2x the 30-day cost share for Tiers 1 & 2, 3x the 30-day cost share for Tier 3. Specialty drugs limited to 30-day supply at a network pharmacy. Certain drugs may have a preauthorization requirement. If you don't get preauthorization, benefits will not be covered. Certain preventive medications (including certain contraceptives) are covered at No Charge, Prescription drug costs are subject to the annual deductible. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 2 – Your Mid-Range Cost Option	$120 copay	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	$200 copay	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	

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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay per service	Not Covered	None
	Physician/surgeon fees	0% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	$875 copay per visit	$875 copay per visit	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	$90 copay per visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copay per admission	Not Covered	None
	Physician/surgeon fees	0% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$60 copay per visit	Not Covered	Network: Partial hospitalization/intensive outpatient treatment: 0% coinsurance Intensive Behavior Therapy (ABA), TMS, ECT, MAT and Psych Testing: $60 copay per visit
	Inpatient services	$1,500 copay per admission	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	None
	Childbirth/delivery professional services	0% coinsurance	Not Covered	
	Childbirth/delivery facility services	$1,500 copay per admission	Not Covered	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	None
	Rehabilitation services	$90 copay per visit	Not Covered	Limits per calendar year: Physical, Occupational: 44 visits combined with speech. Speech, Cardiac: Unlimited; Pulmonary: 20 visits. Physical and Occupational therapy limits do not apply to treatment for autism or if a part of home

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)	
				health care.
	Habilitative services	$90 copay per visit	Not Covered	Limits per calendar year: Physical, Occupational: 44 visits combined with speech. Speech: Unlimited. Physical and Occupational therapy limits do not apply to treatment for autism.
	Skilled nursing care	$1,500 copay per admission	Not Covered	Skilled Nursing is limited to 100 days per calendar year. Inpatient rehabilitation limited to 60 days.
	Durable medical equipment	0% coinsurance	Not Covered	None
	Hospice services	0% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	$30 copay per visit	Not Covered	Limited to 1 exam every 12 months.
	Children's glasses	50% coinsurance	Not Covered	Limited to 1 pair every 12 months. You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both.
	Children's dental check-up	0% coinsurance	Not Covered	Cleanings are covered 2 times every 12 months. Additional limitations may apply.

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
- Cosmetic surgery
- Dental care (adult)
- Glasses (adult)
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine eye care (adult)
- Routine foot care – Except as covered for Diabetes

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

- Abortion
- Bariatric surgery
- Chiropractic (Manipulative care)
- Hearing aids - $2,000 per ear every 36 months
- Infertility treatment
- Weight loss programs

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 dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa, Massachusetts Division of Insurance at 1-617-521-7794 or mass.gov/ocabr/government/oca- agencies/doi-lp or Office of Personnel Management Multi State Plan Program: opm.gov/healthcare-insurance/multi-state-plan-program/external-review/. 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 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: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or Massachusetts Division of Insurance at 1-617-521-7794 or mass.gov/ocabr/government/oca- agencies/doi-lp.
Additionally, a consumer assistance program may help you file your appeal. Contact Massachusetts Division of Insurance at 1-617-521-7794 or mass.gov/ocabr/government/oca- agencies/doi-lp.

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? **Not Applicable**
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 1-877-856-2429.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-877-856-2429.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-856-2429.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-877-856-2429 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-856-2429.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-877-856-2429.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-856-2429.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-877-856-2429.

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	$3,600
Specialist copay	$90
Hospital (facility) copay	$1,500
Other coinsurance	0%

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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,600
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,670**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,600
Specialist copay	$90
Hospital (facility) copay	$1,500
Other coinsurance	0%

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$00
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,600
Specialist copay	$90
Hospital (facility) copay	$1,500
Other coinsurance	0%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.