



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?	<u>Network</u> : \$2,000 Individual / \$4,000 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
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 <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 <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	<u>Network</u> : \$9,200 Individual / \$18,400 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> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <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 charge</u> 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 referral to see a specialist?	Yes. An electronic <u>referral</u> is required to see a <u>Network Specialist</u>	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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
		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	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Virtual visits – No Charge by a Designated Virtual <u>Network Provider</u> . *Cost share applies to any other Telehealth service based on <u>provider</u> type. If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Specialist</u> visit	\$60 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	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)	Lab Testing: \$25 <u>copay</u> per service X-Ray/Diagnostic: \$50 <u>copay</u> per service	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$350 <u>copay</u> per service	Not Covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at uhc.com/xmadruglist3tier2024	Tier 1 – Your Lowest Cost Option	\$30 <u>copay</u> , <u>deductible</u> does not apply.	Not Covered	<u>Provider</u> 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 <u>network pharmacy</u> . Certain drugs may have a <u>preauthorization</u> requirement. If you don't get <u>preauthorization</u> , benefits will not be covered. Certain preventive medications (including certain contraceptives) are covered at No Charge. Prescription drug costs are subject to the annual <u>deductible</u> . See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered.
	Tier 2 – Your Mid-Range Cost Option	\$55 <u>copay</u> , <u>deductible</u> does not apply.	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	\$75 <u>copay</u>	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 <u>copay</u> per service	Not Covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$350 <u>copay</u> per visit	\$350 <u>copay</u> per visit	None
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$60 <u>copay</u> per admission, <u>deductible</u> does not apply.	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,000 <u>copay</u> per admission	Not Covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	<u>Network</u> : Partial <u>hospitalization/intensive</u> outpatient treatment: 0% <u>coinsurance</u> Intensive Behavior Therapy (ABA), TMS, ECT, MAT and Psych Testing: \$25 <u>copay</u> per visit, <u>deductible</u> does not apply.
	Inpatient services	\$1,000 <u>copay</u> per admission	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	None
	Childbirth/delivery professional services	0% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	\$1,000 <u>copay</u> per admission	Not Covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	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 <u>home health care</u> .
	<u>Rehabilitation services</u>	\$60 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	
	<u>Habilitative services</u>	\$60 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Limits per calendar year: Physical, Occupational: 44 visits combined with speech. Speech: Unlimited.

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)	
				Physical and Occupational therapy limits do not apply to treatment for autism.
	<u>Skilled nursing care</u>	\$1,000 <u>copay</u> per admission	Not Covered	Skilled Nursing is limited to 100 days per calendar year. Inpatient rehabilitation limited to 60 days.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	Not Covered	None
	<u>Hospice services</u>	0% <u>coinsurance</u>	Not Covered	None
If your child needs dental or eye care	Children's eye exam	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Limited to 1 exam every 12 months.
	Children's glasses	50% <u>coinsurance</u> , <u>deductible</u> does not apply.	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% <u>coinsurance</u>	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.)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (adult) • Glasses (adult) 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when travelling outside - the U.S. 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Abortion • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic (Manipulative care) • Hearing aids - \$2,000 per ear every 36 months 	<ul style="list-style-type: none"> • 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](https://www.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](https://www.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/](https://www.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](https://www.myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [dol.gov/ebsa/healthreform](https://www.dol.gov/ebsa/healthreform) or Massachusetts Division of Insurance at 1-617-521-7794 or [mass.gov/ocabr/government/oca-agencies/doi-lp](https://www.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](https://www.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, kwijigo holne' 1-877-856-2429.

Pennsylvania Dutch (Deitsch): Fer Hilf griegie in Deitsch, ruf 1-877-856-2429 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-856-2429.

Samoa (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, â'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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall <u>deductible</u>	\$2,000	■ The <u>plan's</u> overall <u>deductible</u>	\$2,000	■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist copay</u>	\$60	■ <u>Specialist copay</u>	\$60	■ <u>Specialist copay</u>	\$60
■ <u>Hospital (facility) copay</u>	\$1,000	■ <u>Hospital (facility) copay</u>	\$1,000	■ <u>Hospital (facility) copay</u>	\$1,000
■ <u>Other coinsurance</u>	0%	■ <u>Other coinsurance</u>	0%	■ <u>Other coinsurance</u>	0%
<p>This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>pre-natal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,000	<u>Deductibles</u>	\$100	<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0	<u>Copayments</u>	\$200	<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$2,060	The total Joe would pay is	\$300	The total Mia would pay is	\$2,500

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