UnitedHealthcare UHC Silver Zero Value Coverage for: Individual, Family|Plan Type: HMO

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 1-866-569-2094 or visit <u>uhc.com/aca-sample-policy</u>. 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 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?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Yes.	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.
Are there other <u>deductibles</u> 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> ?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a network provider?	Yes. See <u>uhc.com/xscdocfindoa2024</u> or call 1-866-569-2094 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 <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 <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	No Charge	None

UnitedHealthcare of South Carolina, Inc.

EXSC24HM0116488 001

Common Medical Event	al Event Services You May Need What You Will Pay		Limitations, Exceptions, & Other Important	
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	Information
	Specialist visit	No Charge	No Charge	None
	Preventive care/screening/ immunization	No Charge	No Charge	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	Diagnostic test (x-ray, blood work)	No Charge	No Charge	None
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	None
If you need drugs to treat	Tier 1 - Your Lowest Cost Option	No Charge	No Charge	Provider means pharmacy for purposes of this
your illness or condition	Tier 2 - Your Lower Cost Option	No Charge	No Charge	section. Retail: One month supply up to a 30-day supply or
More information about prescription drug	Tier 3 - Your Mid-Range Cost Option	No Charge	No Charge	a 90-day supply at 2.5x the 30-day cost share. Mail-Order: Up to a 90-day supply at 2.5x the 30-day cost share. Specialty drugs limited to a 30-day supply at a network pharmacy.
is available at	Tier 4 - Your Mid-Range Cost Option	No Charge	No Charge	
uhc.com/xscdruglist2024	Tier 5 - Your Higher Cost Option	No Charge	No Charge	Certain drugs may have a <u>preauthorization</u> requirement. If you don't get <u>preauthorization</u> ,
	Tier 6 - Your Highest Cost Option	No Charge	No Charge	benefits will not be covered. Certain preventive medications (including certain contraceptives) are 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)	No Charge	No Charge	None
	Physician/surgeon fees	No Charge	No Charge	None
medical attention	Emergency room care	No Charge	No Charge	None
	Emergency medical transportation	No Charge	No Charge	None
	<u>Urgent care</u>	No Charge	No Charge	Virtual visits - No Charge by a Designated Virtual Provider .
If you have a hospital	Facility fee (e.g., hospital room)	No Charge	No Charge	None
stay	Physician/surgeon fees	No Charge	No Charge	None

EXSC24HM0116488_001 Page 2 of 5

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	Information
If you need mental health, behavioral health, or	Outpatient services	Office Visit: No Charge Outpatient: No Charge	Office Visit: No Charge Outpatient: No Charge	None
substance abuse services	Inpatient services	No Charge	No Charge	None
If you are pregnant	Office visits	No Charge	No Charge	None
	Childbirth/delivery professional services	No Charge	No Charge	
	Childbirth/delivery facility services	No Charge	No Charge	
If you need help	Home health care	No Charge	No Charge	Limited to 60 visits/year.
recovering or have other special health needs	Rehabilitation services	No Charge	No Charge	Limits/year: Physical, Occupational, Speech: 30 visits each; Cardiac, Pulmonary: Unlimited visits each
	Habilitative services	No Charge	No Charge	Limits/year: Physical, Occupational, Speech: Unlimited visits each
	Skilled nursing care	No Charge	No Charge	Limited to 60 days/year (combined with inpatient rehabilitation)
	Durable medical equipment	No Charge	No Charge	None
	Hospice services	No Charge	No Charge	Limited to 6 months per episode of care.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Limited to 1 exam/12 months.
	Children's glasses	No Charge	No Charge	Limited to 1 pair/12 months.
	Children's dental check-up	No Charge	No Charge	Limited to 2 visits/12 months.

EXSC24HM0116488_001 Page 3 of 5

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.)

- Abortion (except in cases of rape, incest, or when the life Glasses (Adult)
- of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery Dental care (Adult)

- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care except as covered for diabetes
- Weight loss programs

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

Chiropractic (manipulative) care

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: UnitedHealthcare of South Carolina, Inc. at 1-866-569-2094 or U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/agencies/ebsa/about-ebsa/ask-a-guestion/ask-ebsa or South Carolina Department of Insurance, 1201 Main Street, Suite 1000, Columbia, SC 29201, 1-803-737-6160 or doi.sc.gov 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 Health Care.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 on how 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/exchange or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/agencies/ebsa/about-ebsa/ask-a-question/askebsa or South Carolina Department of Insurance at 803-737-6160 or doi.sc.gov.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

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 1-866-569-2094

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-569-2094

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-569-2094

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-569-2094

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

EXSC24HM0116488 001 Page 4 of 5

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)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Diagnostic tests (ultrasounds and blood work)

Specialist office visits (pre-natal care)

Childbirth/Delivery Facility Services

Specialist visit (anesthesia)

Childbirth/Delivery Professional Services

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Managing Joe's Type 2 Diabetes

(a year of routine in-<u>network</u> care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$0
Hospital (facility) coinsurance	0%
Other <u>coinsurance</u>	0%

Other coinsurance This EXAMPLE event includes services like:

Mia's Simple Fracture

(in-network emergency room visit and

follow up care)

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

\$5,600

\$0 \$0

\$0

\$0

\$0

<u>Durable medical equipment</u> (crutches)

■ The plan's overall deductible

■ Hospital (facility) coinsurance

■ Specialist copayment

Rehabilitation services (physical therapy)

Total Example Cost \$12,700 **Total Example Cost** In this example, Peg would pay: In this example, Joe would pay: Cost Sharing Cost Sharing Deductibles \$0 **Deductibles** \$0 Copayments Copayments \$0 Coinsurance Coinsurance What isn't covered What isn't covered Limits or exclusions \$60 Limits or exclusions The total Peg would pay is \$60 The total Joe would pay is

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$0	
Copayments	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$0	

\$0

\$0