



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/individual-and-family/medical-policy](http://uhc.com/individual-and-family/medical-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/](http://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 <u>deductible</u> ?	\$0	See the Common Medical Events Chart below for your costs for services this plan covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and categories with a <u>copay</u> are covered before you meet your <u>deductible</u> .	See the Common Medical Events Chart below for your costs for services this plan covers.
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 limit</u> for this <u>plan</u> ?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	<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 <u>network provider</u> ?	Yes. See <a href="http://uhc.com/xmadocfind2021">uhc.com/xmadocfind2021</a> 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 <u>referral</u> to see a <u>specialist</u> ?	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 with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	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	No Charge	Not Covered	Not Covered	Virtual visits (Telehealth) – No Charge by a Designated Virtual <u>Network Provider</u>
	<u>Specialist</u> visit	No Charge	Not Covered	Not Covered	None
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	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)	No Charge	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	Not Covered	None
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://uhc.com/xmadruglist3tier2021">uhc.com/xmadruglist3tier2021</a>	Tier 1 – Your Lowest Cost Option	No Charge.	No Charge	Not Covered	<p><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.  *or Preferred 90 Day Retail Network Pharmacy  You may need to obtain certain drugs, including certain <u>specialty drugs</u>, from a pharmacy designated by us.  Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost.  If you use an out-of-<u>network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u>.  Certain preventive medications (including certain contraceptives) are covered at No Charge.  See the website listed for information on drugs covered by your <u>plan</u>. Not all drugs are covered.  You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.</p>
	Tier 2 – Your Mid-Range Cost Option	No Charge	No Charge	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	No Charge	No Charge	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	Not Applicable	

\* For more information about limitations and exceptions, see the plan or policy document at [uhc.com/individual-and-family/medical-policy](http://uhc.com/individual-and-family/medical-policy).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
					If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable <u>copay</u> and/or <u>coinsurance</u> may be applied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	No Charge	No Charge	No Charge	None
	<u>Emergency medical transportation</u>	No Charge	No Charge	No Charge	None
	<u>Urgent care</u>	No Charge	No Charge	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Not Covered	None
	Physician/surgeon fees	No Charge	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	No Charge	Not Covered	Network Partial hospitalization/intensive outpatient treatment: No Charge
	Inpatient services	No Charge	No Charge	Not Covered	None
If you are pregnant	Office visits	No Charge	No Charge	Not Covered	None
	Childbirth/delivery professional services	No Charge	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge	No Charge	Not Covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	No Charge	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 health care.
	<u>Rehabilitation services</u>	No Charge	No Charge	Not Covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [uhc.com/individual-and-family/medical-policy](http://uhc.com/individual-and-family/medical-policy).

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		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Habilitative services</u>	No Charge	No Charge	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.
	<u>Skilled nursing care</u>	No Charge	No Charge	Not Covered	Skilled Nursing is limited to 100 days per calendar year. Inpatient rehabilitation limited to 60 days.
	<u>Durable medical equipment</u>	No Charge	No Charge	Not Covered	None
	<u>Hospice services</u>	No Charge	No Charge	Not Covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	No Charge	Not Covered	Limited to 1 exam every 12 months.
	Children's glasses	No Charge	No Charge	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	No Charge	No Charge	Not Covered	Cleanings are covered 2 times every 12 months. Additional limitations may apply.

### Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care</li> <li>Glasses</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when travelling outside - the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private duty nursing</li> <li>Routine eye care (adult)</li> <li>Routine foot care – Except as covered for Diabetes</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>Abortion</li> <li>Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic (Manipulative care)</li> <li>Hearing aids - \$2,000 per ear every 36 months</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Weight loss programs</li> </ul>

\* For more information about limitations and exceptions, see the plan or policy document at [uhc.com/individual-and-family/medical-policy](http://uhc.com/individual-and-family/medical-policy).

**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 [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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](http://myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform) or Massachusetts Division of Insurance at 1-617-521-7794 or [mass.gov/ocabr/government/oca-agencies/doi-lp](http://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](http://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? 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 1-877-856-2429.

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

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-856-2429.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 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)																																											
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<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>																																											
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>																																										
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The plan would be responsible for the other costs of these EXAMPLE covered services.