




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> : \$250 Individual / \$500 Family Per calendar year. | 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. <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 <u>out-of-pocket limit</u> for this <u>plan</u>? | <u>Network</u> : \$2,800 Individual / \$5,600 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 <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 uhc.com/xnydocfind2023 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 (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 | \$15 <u>copay</u> per visit, <u>deductible</u> applies | Not Covered | Virtual visits – \$15 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> , <u>deductible</u> applies. If you receive services in addition to office visit, additional <u>copays</u> or <u>coinsurance</u> may apply e.g. surgery. If you receive services in addition to office visit, additional <u>copays</u> or <u>coinsurance</u> may apply e.g. surgery. 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. |
| | <u>Specialist</u> visit | \$35 <u>copay</u> per visit, <u>deductible</u> applies. | Not Covered | |
| | <u>Preventive care/screening/immunization</u> | No Charge | Not Covered | |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | \$35 <u>copay</u> per service, <u>deductible</u> applies. | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | \$35 <u>copay</u> per service, <u>deductible</u> applies. | Not Covered | |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at uhc.com/xnydruglist2023 | Tier 1 – Your Lowest Cost Option | \$9 <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 30-day supply. Mail-Order: Up to a 90-day supply at 2.5x the 30-day cost share. 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, <u>Deductible</u> does not apply. 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 | \$20 <u>copay</u> , <u>deductible</u> does not apply. | Not Covered | |
| | Tier 3 – Your Mid-Range Cost Option | \$40 <u>copay</u> , <u>deductible</u> does not apply. | Not Covered | |
| | Tier 4 – Your Highest Cost Option | Not Applicable | Not Applicable | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$75 <u>copay</u> per service, <u>deductible</u> applies. | Not Covered | Referral is only required if referred by a specialist. |

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|---|---|--|---|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Physician/surgeon fees | 10% <u>coinsurance</u> , <u>deductible</u> applies. | Not Covered | Referral is only required if referred by a specialist. |
| If you need immediate medical attention | <u>Emergency room care</u> | \$75 <u>copay</u> per visit, <u>deductible</u> applies. | \$75 <u>copay</u> per visit, <u>deductible</u> applies. | None |
| | <u>Emergency medical transportation</u> | 10% <u>coinsurance</u> , <u>deductible</u> applies. | 10% <u>coinsurance</u> , <u>deductible</u> applies. | None |
| | <u>Urgent care</u> | \$50 <u>copay</u> per visit, <u>deductible</u> applies. | Not Covered | If you receive services in addition to office visit, additional <u>copays</u> or <u>coinsurance</u> may apply e.g. surgery. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$250 <u>copay</u> per admission, <u>deductible</u> applies. | Not Covered | Referral is only required if referred by a specialist. |
| | Physician/surgeon fees | 10% <u>coinsurance</u> , <u>deductible</u> applies. | Not Covered | Referral is only required if referred by a specialist. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$15 <u>copay</u> per visit, <u>deductible</u> does not apply. | Not Covered | <u>Network</u> Partial <u>hospitalization</u> /intensive outpatient treatment: \$15 <u>copay</u> per visit, <u>deductible</u> applies |
| | Inpatient services | \$250 <u>copay</u> per admission, <u>deductible</u> applies. | Not Covered | None |
| If you are pregnant | Office visits | No Charge | Not Covered | None |
| | Childbirth/delivery professional services | 10% <u>coinsurance</u> , <u>deductible</u> applies. | Not Covered | |
| | Childbirth/delivery facility services | \$250 <u>copay</u> per admission, <u>deductible</u> applies. | Not Covered | None |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 10% <u>coinsurance</u> , <u>deductible</u> applies. | Not Covered | Limited to 40 visits per calendar year. |
| | <u>Rehabilitation services</u> | \$25 <u>copay</u> per visit, <u>deductible</u> applies. | Not Covered | Limits per condition per calendar year: Physical/Occupational/ Speech: combined limit 60 visits; Cardiac: Unlimited; Pulmonary: Unlimited. |
| | <u>Habilitative services</u> | \$25 <u>copay</u> per visit, <u>deductible</u> applies. | Not Covered | Limits per condition per calendar year: Physical/Occupational/ Speech: combined limit 60 visits |

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|---|----------------------------------|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | <u>Skilled nursing care</u> | \$250 <u>copay</u> per admission, <u>deductible</u> applies. | Not Covered | Skilled Nursing is limited to 200 days per calendar year. Inpatient rehabilitation limited to 60 days. |
| | <u>Durable medical equipment</u> | 10% <u>coinsurance</u> , <u>deductible</u> applies. | Not Covered | None |
| | <u>Hospice services</u> | 10% <u>coinsurance</u> , <u>deductible</u> applies. | Not Covered | Limited to 210 days per calendar year |
| If your child needs dental or eye care | Children's eye exam | \$15 <u>copayment</u> , <u>deductible</u> applies. | Not Covered | Limited to 1 exam every 12 months. |
| | Children's glasses | 10% <u>coinsurance</u> , <u>deductible</u> applies. | 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 | \$15 <u>copayment</u> , <u>deductible</u> applies. | Not Covered | Cleanings are covered 1 time every 6 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"> • 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. • Private duty nursing | <ul style="list-style-type: none"> • 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 <u>plan</u> document.) | | |
| <ul style="list-style-type: none"> • Abortion • Bariatric surgery | <ul style="list-style-type: none"> • Chiropractic (Manipulative care) • Hearing aids | <ul style="list-style-type: none"> • Infertility treatment |

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, New York Department of Financial Services at 1-800-342-3736 or dfs.ny.gov/index.html 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 New York Department of Financial Services at 1-800-342-3736 or dfs.ny.gov/index.html. 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.

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) | |
|---|-----------------|---|----------------|---|----------------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$250 | ■ The <u>plan's</u> overall <u>deductible</u> | \$250 | ■ The <u>plan's</u> overall <u>deductible</u> | \$250 |
| ■ <u>Specialist copay</u> | \$35 | ■ <u>Specialist copay</u> | \$35 | ■ <u>Specialist copay</u> | \$35 |
| ■ <u>Hospital (facility) copay</u> | \$250 | ■ <u>Hospital (facility) copay</u> | \$250 | ■ <u>Hospital (facility) copay</u> | \$250 |
| ■ <u>Other coinsurance</u> | 10% | ■ <u>Other coinsurance</u> | 10% | ■ <u>Other coinsurance</u> | 10% |
| <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> | \$200 | <u>Deductibles</u> | \$200 | <u>Deductibles</u> | \$200 |
| <u>Copayments</u> | \$600 | <u>Copayments</u> | \$800 | <u>Copayments</u> | \$400 |
| <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 | \$860 | The total Joe would pay is | \$1,000 | The total Mia would pay is | \$600 |

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