



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 1-800-331-4680 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: \$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 deductible 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 Services</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 annual <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? | Network: \$7,250 Individual / \$14,500 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, 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/xohdocfindg2023 or call 1-800-331-4680 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 | No Charge | Not Covered | Virtual visits - No Charge by a Designated Virtual <u>Network Provider</u> . 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 visit</u> | \$85 <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> 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 | Diagnostic test (x-ray, blood work) | Lab Testing: Free Standing/Office: \$15 <u>copay</u> per service, <u>deductible</u> applies Hospital: \$100 <u>copay</u> per service, <u>deductible</u> applies X-Ray/Diagnostics: Free Standing/Office: \$35 <u>copay</u> per service, <u>deductible</u> applies Hospital: \$60 <u>copay</u> per service, <u>deductible</u> applies | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | Free Standing/Office: \$200 <u>copay</u> per service, <u>deductible</u> applies Hospital: \$300 <u>copay</u> per service, <u>deductible</u> applies | Not Covered | None |

| 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 need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at uhc.com/xohdruglist2023 | Tier 1 - Your Lowest Cost Option | Preferred Pharmacy: \$3 <u>copay</u> per prescription, <u>deductible</u> does not apply. Non-Preferred Pharmacy: \$12 <u>copay</u> per prescription, <u>deductible</u> does not apply. | Not Covered | <p><u>Provider</u> means pharmacy for purposes of this section.</p> <p>Retail: Up to a 30-day supply; 90-day supply at Preferred Pharmacy for 2x 30-day cost share.</p> <p>Mail-Order: Up to a 90-day supply at 2x the 30-day cost share.</p> <p>Specialty drugs limited to 30-day supply at a <u>network</u> pharmacy. Certain drugs may have a <u>preauthorization</u> requirement. If you don't get <u>preauthorization</u>, benefits will not be covered.</p> <p>Certain preventive medications (including certain contraceptives) are covered at No Charge, <u>Deductible</u> does not apply.</p> <p>See the website listed for information on drugs covered by your <u>plan</u>. Not all drugs are covered.</p> |
| | Tier 2 - Your Mid-Range Cost Option | Preferred Pharmacy: \$30 <u>copay</u> per prescription, <u>deductible</u> does not apply. Non-Preferred Pharmacy: \$30 <u>copay</u> per prescription, <u>deductible</u> does not apply. | Not Covered | |
| | Tier 3 - Your Mid-Range Cost Option | Preferred Pharmacy: \$85 <u>copay</u> per prescription, <u>deductible</u> applies. Non-Preferred Pharmacy: \$85 <u>copay</u> per prescription, <u>deductible</u> applies. | Not Covered | |
| | Tier 4 – Your Higher Cost Option | Preferred Pharmacy: 40% <u>coinsurance</u> , <u>deductible</u> applies. Non-Preferred Pharmacy: 40% <u>coinsurance</u> , <u>deductible</u> applies. | Not Covered | |
| | Tier 5 – Your Higher Cost Option | Preferred Pharmacy: 50% <u>coinsurance</u> , <u>deductible</u> applies. Non-Preferred Pharmacy: 50% <u>coinsurance</u> , <u>deductible</u> applies. | Not Covered | |

| 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) | \$375 <u>copay</u> per visit, <u>deductible</u> applies | Not Covered | None |
| | Physician/surgeon fees | Free Standing/Office: \$375 <u>copay</u> , <u>deductible</u> applies Hospital: \$750 <u>copay</u> , <u>deductible</u> applies | Not Covered | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$1,000 <u>copay</u> per visit, <u>deductible</u> applies | \$1,000 <u>copay</u> per visit, <u>deductible</u> applies | None |
| | <u>Emergency medical transportation</u> | 50% <u>coinsurance</u> , <u>deductible</u> applies | 50% <u>coinsurance</u> , <u>deductible</u> applies | None |
| | <u>Urgent Care</u> | \$75 <u>copay</u> per visit, <u>deductible</u> does not apply | Not Covered | If you receive services in addition to <u>Urgent care</u> visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$1,500 <u>copay</u> per day up to 3 days, <u>deductible</u> applies | Not Covered | None |
| | Physician/surgeon fees | 50% <u>coinsurance</u> , <u>deductible</u> applies | Not Covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit: \$85 <u>copay</u> per visit, <u>deductible</u> applies | Not Covered | <u>Network</u> Partial <u>hospitalization</u> /intensive outpatient treatment: \$375 <u>copay</u> , <u>deductible</u> applies. |
| | Inpatient services | \$1,500 <u>copay</u> per day up to 3 days, <u>deductible</u> applies | Not Covered | None |

| 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 are pregnant | Office Visits | No Charge | Not Covered | <u>Cost sharing</u> does not apply for <u>preventive services</u> . |
| | Childbirth/delivery professional services | 50% <u>coinsurance</u> , <u>deductible</u> applies | Not Covered | Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). |
| | Childbirth/delivery facility services | \$1,500 <u>copay</u> per day up to 3 days, <u>deductible</u> applies | Not Covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 50% <u>coinsurance</u> , <u>deductible</u> applies | Not Covered | Limited to 100 visits per calendar year. |
| | <u>Rehabilitation services</u> | \$85 <u>copay</u> per visit, <u>deductible</u> applies | Not Covered | Limits per calendar year: Physical, Occupational, Speech, Pulmonary: 20 visits each; Cardiac: 36 visits. |
| | <u>Habilitative services</u> | \$85 <u>copay</u> per visit, <u>deductible</u> applies | Not Covered | Limits per calendar year: Physical, Occupational, Speech: 20 visits each. |
| | <u>Skilled nursing care</u> | \$1,500 <u>copay</u> per day up to 3 days, <u>deductible</u> applies | Not Covered | Limited to 90 days per calendar year (combined with inpatient rehabilitation). |
| | <u>Durable medical equipment</u> | 50% <u>coinsurance</u> , <u>deductible</u> applies | Not Covered | None |
| | <u>Hospice services</u> | 50% <u>coinsurance</u> , <u>deductible</u> applies | Not Covered | None |
| If your child needs dental or eye care | Children's eye exam | No Charge | Not Covered | Limited to 1 exam every 12 months. |
| | Children's glasses | 50% <u>coinsurance</u> , <u>deductible</u> applies | Not Covered | Limited to 1 pair every 12 months. |

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|----------------------|----------------------------|---|---|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Children's dental check-up | No Charge | Not Covered | Limited to 2 visits every 12 months. |

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 | • Dental care (Adult) | • Non-emergency care when traveling outside - the US |
| • Acupuncture | • Glasses (Adult) | • Routine eye care (Adult) |
| • Bariatric surgery | • Hearing aids | • Routine foot care - Except as covered for Diabetes |
| • Cosmetic Surgery | • Long Term Care | • 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 - 12 visits per calendar year | • Infertility treatment - diagnosis and treatment of underlying causes | • Private duty nursing - 90 visits per calendar year |
|--|--|--|

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 Ohio, Inc. at 1-800-331-4680, 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) or Ohio Department of Insurance, 50 W. Town Street, #300, Columbus, OH 43215, 1-800-686-1526 or insurance.ohio.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 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 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 <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa> or Ohio Department of Insurance at 1-800-686-1526 or insurance.ohio.gov. Additionally, a consumer assistance program may help you file your appeal. Contact <https://www.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 1-800-331-4680.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-331-4680.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-331-4680.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-331-4680.

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 plan's overall deductible | \$2,000 | ■ The plan's overall deductible | \$2,000 | ■ The plan's overall deductible | \$2,000 |
| ■ Specialist copay | \$85 | ■ Specialist copay | \$85 | ■ Specialist copay | \$85 |
| ■ Hospital (facility) copay | \$1,500 | ■ Hospital (facility) copay | \$1,500 | ■ Hospital (facility) copay | \$1,500 |
| ■ Other coinsurance | 50% | ■ Other coinsurance | 50% | ■ Other coinsurance | 50% |
| This EXAMPLE event includes services like: Specialist office visits (<i>pre-natal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>) | | This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>) | | This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>) | |
| 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: | |
| <u>Cost Sharing</u> | | <u>Cost Sharing</u> | | <u>Cost Sharing</u> | |
| Deductibles | \$2,000 | Deductibles | \$300 | Deductibles | \$2,000 |
| Copayments | \$1,600 | Copayments | \$700 | Copayments | \$600 |
| Coinsurance | \$0 | Coinsurance | \$200 | Coinsurance | \$60 |
| <u>What isn't covered</u> | | <u>What isn't covered</u> | | <u>What isn't covered</u> | |
| Limits or exclusions | \$60 | Limits or exclusions | \$0 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$3,660 | The total Joe would pay is | \$1,200 | The total Mia would pay is | \$2,660 |