UnitedHealthcare **UHC Silver Advantage (Unlimited $0 Virtual Urgent Care + $0 Primary Care Visits, $3 T1 Preferred Rx)**

**Coverage For: Individual, Family | Plan Type: HMO**

**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 1-866-811-2704 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<br>Per calendar year. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive Care Services and categories with a copay are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply.<br>For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Network: **$9,100** Individual / **$18,200** Family<br>Per calendar year. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See uhc.com/xtxdocfindg2023 or call 1-866-811-2704 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | Yes. An electronic referral is required to see a Network Specialist. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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 Network Provider.<br>If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. |
| | Specialist visit | $100 copay per visit, deductible does not apply | Not Covered | If you receive services in addition to office visit, additional copays or coinsurance may apply e.g. surgery. |
| | Preventive care/screening/ immunization | No Charge | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab Testing:<br><br>Free Standing/Office: $15 copay per service, deductible applies<br>Hospital: $100 copay per service, deductible applies<br>X-Ray/Diagnostics:<br><br>Free Standing/Office: $35 copay per service, deductible applies<br>Hospital: $60 copay per service, deductible applies | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | Free Standing/Office: $200 copay per service, deductible applies<br>Hospital: $300 copay per service, deductible 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**<br>More information about prescription drug coverage is available at uhc.com/xtxdruglist2023 | Tier 1 - Your Lowest Cost Option | Preferred Pharmacy: $3 copay per prescription, deductible does not apply.<br>Non-Preferred Pharmacy: $12 copay per prescription, deductible does not apply. | Not Covered | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 30-day supply; 90-day supply at Preferred Pharmacy for 2x 30-day cost share.<br>Mail-Order: Up to a 90-day supply at 2x the 30-day cost share.<br>Specialty drugs limited to 30-day supply at a network pharmacy. Certain drugs may have a preauthorization requirement. If you don't get preauthorization, benefits will not be covered.<br>Certain preventive medications (including certain contraceptives) are covered at No Charge, Deductible does not apply.<br>See the website listed for information on drugs covered by your plan. Not all drugs are covered. |
| | Tier 2 - Your Mid-Range Cost Option | Preferred Pharmacy: $30 copay per prescription, deductible does not apply.<br>Non-Preferred Pharmacy: $30 copay per prescription, deductible does not apply. | Not Covered | |
| | Tier 3 - Your Mid-Range Cost Option | Preferred Pharmacy: $85 copay per prescription, deductible applies.<br>Non-Preferred Pharmacy: $85 copay per prescription, deductible applies. | Not Covered | |
| | Tier 4 – Your Higher Cost Option | Preferred Pharmacy: 40% coinsurance, deductible applies.<br>Non-Preferred Pharmacy: 40% coinsurance, deductible applies. | Not Covered | |
| | Tier 5 – Your Higher Cost Option | Preferred Pharmacy: 50% coinsurance, deductible applies.<br>Non-Preferred Pharmacy: 50% coinsurance, deductible 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 copay per visit, deductible applies | Not Covered | None |
| | Physician/surgeon fees | Free Standing/Office: $375 copay, deductible applies Hospital: $750 copay, deductible applies | Not Covered | None |
| **If you need immediate medical attention** | Emergency room care | $1,000 copay per visit, deductible applies | $1,000 copay per visit, deductible applies | None |
| | Emergency medical transportation | 45% coinsurance, deductible applies | 45% coinsurance, deductible applies | None |
| | Urgent Care | $75 copay per visit, deductible does not apply | Not Covered | If you receive services in addition to Urgent care visit, additional copays, deductibles or coinsurance may apply e.g. surgery. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $1,500 copay per day up to 3 days, deductible applies | Not Covered | None |
| | Physician/surgeon fees | 45% coinsurance, deductible applies | Not Covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit: $70 copay per visit, deductible applies | Not Covered | Network Partial hospitalization/intensive outpatient treatment: $375 copay, deductible applies. |
| | Inpatient services | $1,500 copay per day up to 3 days, deductible 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 | Cost sharing does not apply for preventive services.<br><br>Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). |
| | Childbirth/delivery professional services | 45% coinsurance, deductible applies | Not Covered | |
| | Childbirth/delivery facility services | $1,500 copay per day up to 3 days, deductible applies | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | 45% coinsurance, deductible applies | Not Covered | Limited to 60 visits per calendar year. |
| | Rehabilitation services | $100 copay per visit, deductible applies | Not Covered | Limits per calendar year: Cardiac, Pulmonary: Unlimited; Physical/Occupational/Speech/Manipulative: combined limit 35 visits.<br>No limits apply for Acquired Brain Injury services. |
| | Habilitative services | $100 copay per visit, deductible applies | Not Covered | Limits per calendar year: Physical/Occupational/Speech/ Manipulative: combined limit 35 visits. No limits apply for treatment of covered mental health or substance use disorders. |
| | Skilled nursing care | $1,500 copay per day up to 3 days, deductible applies | Not Covered | Limited to 25 days per calendar year (combined with inpatient rehabilitation). |
| | Durable medical equipment | 45% coinsurance, deductible applies | Not Covered | None |
| | Hospice services | 45% coinsurance, deductible 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. |

| 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) | |
| | Children's glasses | 45% coinsurance, deductible applies | Not Covered | Limited to 1 pair every 12 months. |
| | 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
- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental care (Adult)
- Glasses (Adult)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside - the US
- 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 - 35 visits per calendar year combined with PT/OT/ST
- Hearing aids

**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 Texas, Inc. at 1-866-811-2704, 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 or Texas Department of Insurance, 333 Guadalupe, Austin, TX 78701, 1-800-252-3439 or tdi.texas.gov/consumer/index, 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 Texas Department of Insurance at 1-512-676-6365 or tdi.texas.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 1-866-811-2704.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-811-2704.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-866-811-2704.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-811-2704.

*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)

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist copay | $100 |
| Hospital (facility) copay | $1,500 |
| Other coinsurance | 45% |

**This EXAMPLE event includes services like:**
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| Total Example Cost | $12,700 |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,000 |
| Copayments | $1,600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,660** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist copay | $100 |
| Hospital (facility) copay | $1,500 |
| Other coinsurance | 45% |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| Total Example Cost | $5,600 |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $300 |
| Copayments | $800 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,200** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist copay | $100 |
| Hospital (facility) copay | $1,500 |
| Other coinsurance | 45% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| Total Example Cost | $2,800 |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,000 |
| Copayments | $600 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,660** |



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