Essential Plan 200 - 250

Coverage Period: 01/01/2024 - 12/31/2024
Coverage for: Individual | **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 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 atwww.cciio.cms.govorwww.healthcare.gov/sbc-glossary or call1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Not Applicable	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes, Preventive Care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible.
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?	In-Network: $2,000 Individual/$0 Family; Out-of-Network: Not Applicable	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?	Costs for premiums, balance billing charges, and 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.	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?	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 Information
		In-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 Copay/visit	Not Covered	None
	Specialist visit	$25 Copay/visit	Not Covered	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: Not Covered	Adult Physical: Not Covered Adult Immunizations: Not Covered Well Child Visit: 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. 1 Exam per 1 CalendarYear
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: $15 PCP; $25 Specialist Copay/visit Blood Work: $15 PCP; $25 Specialist Copay/visit	X-Ray: Not Covered Blood Work: Not Covered	None
	Imaging (CT/PET scans, MRIs)	$25 Specialist Copay/visit	Not Covered	
If you need drugs to treat your illness or condition	Tier 1 (Generic drugs)	$6/prescription retail, $15/ prescription mail order	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)/prescription Preauthorization required. If you don't get a preauthorization, you must pay the entire cost and submit a claim to us for reimbursement.
	Tier 2 (Preferred brand drugs)	$15/prescription retail, $37.50/ prescription mail order	Not Covered	
	Tier 3 (Non-preferred brand drugs)	$30/prescription retail, $75/ prescription mail order	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 Copay	Not Covered	None
	Physician/surgeon fees	$50/surgery Copay	Not Covered	
If you need immediate medical attention	Emergency room care	$75 Copay/visit	$75 Copay/visit	None
	Emergency medical transportation	$75 Copay/visit	$75 Copay/visit	None
	Urgent care	$25 Copay/visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 Copay	Not Covered	None
	Physician/surgeon fees	$50/surgery Copay	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 Copay/visit	Not Covered	None
	Inpatient services	$150 Copay	Not Covered	
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery professional services	$50/delivery Copay	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery facility services	$150 Copay	Not Covered	None
If you need help recovering or have other special health needs	Home health care	$15 Copay	Not Covered	40 Visits per contract year limit
	Rehabilitation services	$15 Copay/visit	Not Covered	60 Visits per contract year limit
	Habilitation services	$15 Copay/visit	Not Covered	60 Visits per contract year limit
	Skilled nursing care	$150 Copay	Not Covered	200 Days per contract year limit
	Durable medical equipment	5% Coinsurance	Not Covered	None
	Hospice services	$15 Copay	Not Covered	210 Days per contract year limit Family bereavement counseling limited to 5 Visits per contract year
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Child)
- Routine foot care
- Weight loss programs

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

- Abortion
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/contactEBSA/consumerassistance.html. 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 phone number on Your ID card or www.univerahealthcare.com; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

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.

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