



**This is only a summary.** It in no way modifies your benefits as described in your plan documents. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.uhcsr.com/pace](http://www.uhcsr.com/pace) or by calling (844) 221-0962.

| Important Questions  | Answers  | Why this Matters:   |
|--|--|---|
| <b>What is the overall deductible?</b>                         | \$35 (Person)  | You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .  |
| <b>Are there other deductibles for specific services?</b>      | Yes. There are other specific <b>deductibles</b> .   | You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.   |
| <b>Is there an out-of-pocket limit on my expenses?</b>         | \$6,350 (Person)<br>\$12,700 (Family)  | The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.  |
| <b>What is not included in the out-of-pocket limit?</b>        | Premiums, balance-billed charges, and health care this plan doesn't cover.   | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .  |
| <b>Is there an overall annual limit on what the plan pays?</b> | No.  | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.   |
| <b>Does this plan use a network of providers?</b>              | Yes. For a list of <b>preferred providers</b> , see <a href="http://www.uhcsr.com/pace">www.uhcsr.com/pace</a> or call (844) 221-0962. | If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |
| <b>Do I need a referral to see a specialist?</b>               | No.  | You can see the <b>specialist</b> you choose without permission from this plan.   |
| <b>Are there services this plan doesn't cover?</b>             | Yes.   | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <b>excluded services</b> .   |

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance (Coins)** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible (ded)**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event   | Services You May Need                            | Your Cost if You Use a Preferred Provider           | Your Cost if You Use a Out of Network Provider | Limitations & Exceptions  |
|--|--|---|--|---|
| <b>If you visit a health care provider's office or clinic</b>  | Primary care visit to treat an injury or illness | 0% Coins<br>\$20 Copay per visit                    | 35% Coins                                      | May not apply when related to surgery or Physiotherapy.   |
|  | Specialist visit                                 | 0% Coins<br>\$20 Copay per visit                    | 35% Coins                                      | May not apply when related to surgery or Physiotherapy.   |
|  | Other practitioner office visit                  | 10% Coins   | 35% Coins                                      | Visit limits may apply.   |
|  | Preventive care/screening/immunization           | No Charge   | 30% Coins                                      | Includes preventive health services specified in the health care reform law or benefits provided as mandated by state law.            |
| <b>If you have a test</b>  | Diagnostic test (x-ray, blood work)              | 10% Coins   | 35% Coins                                      | —————none—————  |
|  | Imaging (CT/PET scans, MRIs)                     | 10% Coins   | 35% Coins                                      | —————none—————  |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.uhcsr.com">www.uhcsr.com</a> | Generic drugs                                    | \$15 Copay per prescription for generic drugs       | Not Covered                                    | Prescription limits may apply. Preferred: (Mail order is available through Express Scripts at 2 times the Copay for a 90 day supply.) |
|  | Preferred brand drugs                            | \$30 Copay per prescription for brand name          | Not Covered                                    |   |
|  | Non-preferred brand drugs                        | \$50 Copay per prescription for non-preferred brand | Not Covered                                    |   |

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| Common Medical Event  | Services You May Need                          | Your Cost if You Use a Preferred Provider | Your Cost if You Use a Out of Network Provider | Limitations & Exceptions  |
|---|--|---|--|---|
|   |  | name                                      |  |   |
|   | Specialty drugs                                | Covered                                   | Not Covered                                    |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center) | 10% Coins                                 | 35% Coins                                      | —————none—————  |
|   | Physician/surgeon fees                         | 10% Coins                                 | 35% Coins                                      | —————none—————  |
| <b>If you need immediate medical attention</b>                                | Emergency room services                        | 0% Coins                                  | 0% Coins                                       | —————none—————  |
|   | Emergency medical transportation               | 10% Coins                                 | 10% Coins                                      | —————none—————  |
|   | Urgent care                                    | 10% Coins                                 | 35% Coins                                      | —————none—————  |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)             | 10% Coins                                 | 35% Coins                                      | —————none—————  |
|   | Physician/surgeon fee                          | 10% Coins                                 | 35% Coins                                      | —————none—————  |
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services   | 0% Coins<br>\$20 Copay per visit          | 35% Coins                                      | —————none—————  |
|   | Mental/Behavioral health inpatient services    | 10% Coins                                 | 35% Coins                                      | —————none—————  |
|   | Substance use disorder outpatient services     | 0% Coins<br>\$20 Copay per visit          | 35% Coins                                      | —————none—————  |
|   | Substance use disorder inpatient services      | 10% Coins                                 | 35% Coins                                      | —————none—————  |
| <b>If you are pregnant</b>  | Prenatal and postnatal care                    | 0% Coins<br>\$20 Copay per visit          | 35% Coins                                      | —————none—————  |
|   | Delivery and all inpatient services            | 10% Coins                                 | 35% Coins                                      | —————none—————  |
| <b>If you need help recovering or have other special health needs</b>         | Home health care                               | 10% Coins                                 | 35% Coins                                      | Visit limits may apply.   |
|   | Rehabilitation services                        | 10% Coins                                 | 35% Coins                                      | Visit limits may apply.   |
|   | Habilitation services                          | 10% Coins                                 | 35% Coins                                      | Visit limits may apply.   |
|   | Skilled nursing care                           | 10% Coins                                 | 35% Coins                                      | Visit/day limits may apply.   |
|   | Durable medical equipment                      | 10% Coins                                 | 35% Coins                                      | —————none—————  |
|   | Hospice service                                | 10% Coins                                 | 35% Coins                                      | Visit limits may apply.   |
| <b>If your child needs dental or eye care</b>                                 | Eye exam                                       | See your plan's Pediatric Vision Plan     | See your plan's Pediatric Vision Plan          | See your plan's Pediatric Vision Benefit Details. Age limits apply. |

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| Common Medical Event | Services You May Need | Your Cost if You Use a Preferred Provider | Your Cost if You Use a Out of Network Provider | Limitations & Exceptions  |
|----------------------|-----------------------|---|--|---|
|                      | Glasses               | See your plan's Pediatric Vision Plan     | See your plan's Pediatric Vision Plan          | See your plan's Pediatric Vision Benefit Details. Age limits apply. |
|                      | Dental check-up       | See your plan's Pediatric Dental Plan     | See your plan's Pediatric Dental Plan          | See your plan's Pediatric Dental Benefit Details. Age limits apply. |

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### Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery except as noted in the policy
- Dental care (Adult) except as noted in the policy
- Long-term Care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care except as noted in the policy
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing Aids
- Infertility treatment except as noted in the policy
- Non-emergency care when traveling outside the U.S.

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### **Your Rights to Continue Coverage:**

If you lose your status as an eligible student under your Student Health Insurance Coverage, Federal and State laws may allow you to continue your health coverage for a limited period of time. Any such rights will be limited in duration and will require you to pay a premium. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the insurer at 1-800-767-0700. You may also contact your state insurance department at New York Department of Financial Services at 1-800-342-3736 or visit <http://www.dfs.ny.gov/index.html>.

### **Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: New York Department of Financial Services at 1-800-342-3736 or visit <http://www.dfs.ny.gov/index.html>.

Additionally, a consumer assistance program can help you file your appeal, contact Community Service Society of New York, Community Health Advocates at 1-888-614-5400 or visit <http://www.communityhealthadvocates.org/>. A list of states with Consumer Assistance Programs is available at <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

### **Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

### **Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-767-0700.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-767-0700.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-767-0700.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-767-0700.

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

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**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

| Having A Baby<br>(normal delivery)   |                |
|--|----------------|
| <ul style="list-style-type: none"> <li>■ Amount owed to providers: \$7,540</li> <li>■ Plan pays: \$6,780</li> <li>■ Patient pays: \$760</li> </ul> |                |
| <b>Sample care costs:</b>  |                |
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care   | \$2,100        |
| Hospital charges (baby)  | \$900          |
| Anesthesia   | \$900          |
| Laboratory tests   | \$500          |
| Prescriptions  | \$200          |
| Radiology  | \$200          |
| Vaccines, other preventive   | \$40           |
| <b>Total</b>   | <b>\$7,540</b> |
| <b>Patient pays:</b>   |                |
| Deductibles  | \$40           |
| Copays   | \$20           |
| Coinsurance  | \$500          |
| Limits or exclusions   | \$200          |
| <b>Total</b>   | <b>\$760</b>   |

| Managing type 2 diabetes<br>(routine maintenance of a well-controlled condition)   |                |
|--|----------------|
| <ul style="list-style-type: none"> <li>■ Amount owed to providers: \$5,400</li> <li>■ Plan pays: \$4,980</li> <li>■ Patient pays: \$420</li> </ul> |                |
| <b>Sample care costs:</b>  |                |
| Prescriptions  | \$2,900        |
| Medical Equipment and Supplies   | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education  | \$300          |
| Laboratory tests   | \$100          |
| Vaccines, other preventive   | \$100          |
| <b>Total</b>   | <b>\$5,400</b> |
| <b>Patient pays:</b>   |                |
| Deductibles  | \$40           |
| Copays   | \$200          |
| Coinsurance  | \$100          |
| Limits or exclusions   | \$80           |
| <b>Total</b>   | <b>\$420</b>   |

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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