



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 1-800-980-5319 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? | \$0 | 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. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| 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? | Not Applicable | This plan does not have an out-of-pocket limit on your expenses. |
| What is not included in the out-of-pocket limit? | Not Applicable | This plan does not have an out-of-pocket limit on your expenses. |
| Will you pay less if you use a network provider? | Yes. See uhc.com/xokdocfindoa2023 or call 1-800-980-5319 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? | No | You can see the specialist you choose without a referral. |



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 |
|--|--|---|--|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No Charge | No Charge | Virtual visits - No Charge by a Designated Virtual <u>Network Provider</u> . |
| | <u>Specialist visit</u> | No Charge | No Charge | None |
| | <u>Preventive care/screening/immunization</u> | No Charge | No Charge | None |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No Charge | No Charge | None |
| | Imaging (CT/PET scans, MRIs) | No Charge | No Charge | None |

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|--|--|---|--|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at uhc.com/xokdruglist2023 | Tier 1 - Your Lowest Cost Option | No Charge | No Charge | <u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 30-day supply; 90-day supply at Preferred Pharmacy for 2x 30-day cost share. Mail-Order: Up to a 90-day supply at 2x the 30-day cost share. 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. 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 | No Charge | No Charge | |
| | Tier 3 - Your Mid-Range Cost Option | No Charge | No Charge | |
| | Tier 4 – Your Higher Cost Option | No Charge | No Charge | |
| | Tier 5 – Your Higher Cost Option | No Charge | No Charge | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge | No Charge | None |
| | Physician/surgeon fees | No Charge | No Charge | None |
| If you need immediate medical attention | <u>Emergency room care</u> | No Charge | No Charge | None |
| | <u>Emergency medical transportation</u> | No Charge | No Charge | None |
| | <u>Urgent Care</u> | No Charge | No Charge | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge | No Charge | None |
| | Physician/surgeon fees | No Charge | No Charge | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|---|--|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No Charge | No Charge | Network Partial <u>hospitalization</u> /intensive outpatient treatment: No Charge. |
| | Inpatient services | No Charge | No Charge | None |
| If you are pregnant | Office Visits | No Charge | No Charge | None |
| | Childbirth/delivery professional services | No Charge | No Charge | |
| | Childbirth/delivery facility services | No Charge | No Charge | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No Charge | No Charge | Limited to 30 visits per calendar year. |
| | <u>Rehabilitation services</u> | No Charge | No Charge | Limits per calendar year: Cardiac, Pulmonary: Unlimited; Physical/Occupational/Speech: combined limit 25 visits. |
| | <u>Habilitative services</u> | No Charge | No Charge | Limits per calendar year: Physical/Occupational/Speech: combined limit 25 visits. A combined therapy limit of 390 visits applies for treatment of Autism Spectrum Disorder Services. |
| | <u>Skilled nursing care</u> | No Charge | No Charge | Skilled Nursing is limited to 30 days per calendar year. Inpatient rehabilitation limited to 30 days. |
| | <u>Durable medical equipment</u> | No Charge | No Charge | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|----------------------------|---|--|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | |
| | <u>Hospice services</u> | No Charge | No Charge | None |
| If your child needs dental or eye care | Children's eye exam | No Charge | No Charge | Limited to 1 exam every 12 months. |
| | Children's glasses | No Charge | No Charge | Limited to 1 pair every 12 months. |
| | Children's dental check-up | No Charge | No Charge | 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 | • Infertility Treatment | • 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 | • Hearing aids | • Private duty nursing - 85 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 Oklahoma, Inc. at 1-800-980-5319, 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 Oklahoma Insurance Department, 400 NE 50th Street, Oklahoma City, OK 73105, 1-405-521-2828 or oid.ok.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 Oklahoma Department of Insurance at 1-800-552-0071 or oid.ok.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 1-800-980-5319.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-980-5319.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-980-5319.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-980-5319.

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 | \$0 | ■ The plan's overall deductible | \$0 | ■ The plan's overall deductible | \$0 |
| ■ Specialist copay | \$0 | ■ Specialist copay | \$0 | ■ Specialist copay | \$0 |
| ■ Hospital (facility) copay | \$0 | ■ Hospital (facility) copay | \$0 | ■ Hospital (facility) copay | \$0 |
| ■ Other coinsurance | 0% | ■ Other coinsurance | 0% | ■ Other coinsurance | 0% |
| 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 | \$0 | Deductibles | \$0 | Deductibles | \$0 |
| Copayments | \$0 | Copayments | \$0 | Copayments | \$0 |
| Coinsurance | \$0 | Coinsurance | \$0 | Coinsurance | \$0 |
| <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 | \$60 | The total Joe would pay is | \$0 | The total Mia would pay is | \$0 |