🗓 UnitedHealthcare® **UHC Gold-B Standard (No Referrals)**

⚠️ 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 1-888-200-0327 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** at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or **$2,000** Individual / **$4,000** Family 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. 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: **$8,700** Individual / **$17,400** Family 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/xaldocfindoa2023 or call 1-888-200-0327 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)	Non-IHCP 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	$30 copay per visit, deductible does not apply	Not Covered	Virtual Visits - $30 copay by a Designated Virtual Network Provider, deductible does not apply. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. Cost-sharing waived at non-IHCP with IHCP referral .
	Specialist visit	No Charge	$60 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. Cost-sharing waived at non-IHCP with IHCP referral .
	Preventive care/ screening/immunization	No Charge	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)	No Charge	Network: 25% coinsurance, deductible applies	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral .
	Imaging (CT/ PET scans, MRIs)	No Charge	25% coinsurance, deductible applies	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral .

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)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at uhc.com/xalQdruglist2023	Tier 1 - Your Lowest Cost Option	No Charge	$15 copay per prescription, deductible does not apply.	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30-day supply. Mail-Order: Up to a 90-day supply at 3x the 30-day cost share. 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. Certain preventive medications (including certain contraceptives) are covered at No Charge, Deductible does not apply. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 2 - Your Mid-Range Cost Option	No Charge	$30 copay per prescription, deductible does not apply.	Not Covered	
	Tier 3 - Your Mid-Range Cost Option	No Charge	$60 copay per prescription, deductible does not apply.	Not Covered	
	Tier 4 – Your Higher Cost Option	No Charge	$250 copay per prescription, deductible does not apply.	Not Covered	
	Tier 5 – Your Higher Cost Option	Not Applicable	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	25% coinsurance, deductible applies	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.
	Physician/ surgeon fees	No Charge	25% coinsurance deductible applies	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.
If you need immediate medical attention	Emergency room care	No Charge	25% coinsurance, deductible applies	25% coinsurance, deductible applies	Cost-sharing waived at non-IHCP with IHCP referral.

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)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	No Charge	25% coinsurance, deductible applies	25% coinsurance, deductible applies	Cost-sharing waived at non-IHCP with IHCP referral.
	Urgent Care	No Charge	$45 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. Cost-sharing waived at non-IHCP with IHCP referral.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	25% coinsurance, deductible applies	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.
	Physician/ surgeon fees	No Charge	25% coinsurance, deductible applies	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Office Visit: $30 copay per visit, deductible does not apply	Not Covered	Network Partial hospitalization/intensive outpatient treatment: 25% coinsurance, deductible applies. Cost-sharing waived at non-IHCP with IHCP referral.
	Inpatient services	No Charge	25% coinsurance, deductible applies	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.
If you are pregnant	Office Visits	No Charge	No Charge	Not Covered	Cost sharing does not apply for preventive services.

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)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	No Charge	25% coinsurance, deductible applies	Not Covered	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.) Cost-sharing waived at non-IHCP with IHCP referral.
	Childbirth/delivery facility services	No Charge	25% coinsurance, deductible applies	Not Covered	
If you need help recovering or have other special health needs	Home health care	No Charge	25% coinsurance, deductible applies	Not Covered	Limited to 60 visits per calendar year. Cost-sharing waived at non-IHCP with IHCP referral.
	Rehabilitation services	No Charge	$30 copay per visit, deductible does not apply	Not Covered	Limits per calendar year: Cardiac, Pulmonary: Unlimited; Physical/Occupational/Speech: combined limit 30 visits. Cost-sharing waived at non-IHCP with IHCP referral.
	Habilitative services	No Charge	$30 copay per visit, deductible does not apply	Not Covered	Limits per calendar year: Physical/Occupational/Speech: combined limit 30 visits. An additional combined limit of 35 visits for speech and occupational therapy applies for treatment of Autism Spectrum Disorder.. Cost-sharing waived at non-IHCP with IHCP referral.

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)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	No Charge	25% coinsurance, deductible applies	Not Covered	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Cost-sharing waived at non-IHCP with IHCP referral.
	Durable medical equipment	No Charge	25% coinsurance, deductible applies	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.
	Hospice services	No Charge	25% coinsurance, deductible applies	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Not Covered	Limited to 1 exam every 12 months. Cost-sharing waived at non-IHCP with IHCP referral.
	Children's glasses	No Charge	25% coinsurance, deductible applies	Not Covered	Limited to 1 pair every 12 months. Cost-sharing waived at non-IHCP with IHCP referral.
	Children's dental check-up	No Charge	No Charge	Not Covered	Limited to 2 visits every 12 months. Cost-sharing waived at non-IHCP with IHCP referral.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services.</u>)

- Abortion
- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental care (Adult)

- Glasses (Adult)
- Hearing aids
- 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 <u>plan</u> document.)

- Chiropractic (manipulative) care - 10 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 Insurance Company at 1-888-200-0327, 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 the Alabama Department of Insurance, 201 Monroe Street, Suite 502, Montgomery, AL 36104, 1-800-433-3966 or aldoi.gov/ Consumers, 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 <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 Alabama Department of Insurance at 1-800-433-3966 or aldoi.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
<u>Minimum Essential Coverage</u> generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

Does this plan meet the Minimum Value Standards? Not Applicable
If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-200-0327.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-200-0327.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-200-0327.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-200-0327.

To see examples of how this <u>plan</u> 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	$60	■ Specialist copay	$60	■ Specialist copay	$60
■ Hospital (facility) coinsurance	25%	■ Hospital (facility) coinsurance	25%	■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%	■ Other coinsurance	25%	■ Other coinsurance	25%

This EXAMPLE event includes services like:

Peg	Joe	Mia
Specialist office visits *(pre-natal care)* Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests *(ultrasounds and blood work)* Specialist visit *(anesthesia)*	Primary care physician office visits *(including disease education)* Diagnostic tests *(blood work)* Prescription drugs Durable medical equipment *(glucose meter)*	Emergency room care *(including medical supplies)* Diagnostic test *(x-ray)* Durable medical equipment *(crutches)* Rehabilitation services *(physical therapy)*

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:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$0	Deductibles	$0	Deductibles	$0
Copayments	$0	Copayments	$0	Copayments	$0
Coinsurance	$0	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$0	Limits or exclusions	$0	Limits or exclusions	$0
The total Peg would pay is	**$0**	**The total Joe would pay is**	**$0**	**The total Mia would pay is**	**$0**

Note: These numbers assume the patient received care from an IHCP or with an IHCP referral to a non-IHCP. If you received care from a non-IHCP without a referral from an IHCP your costs may be higher.