The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 1-877-856-2429 or visit <u>uhc.com/aca-sample-policy</u>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, 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. Network: \$2,100 Individual / \$4,200 Family Per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and categories with a <u>copay</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Network: \$9,450 Individual / \$18,900 Family Per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit.</u>
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>uhc.com/xnydocfind2024</u> or call 1-877-856-2429 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes. An electronic <u>referral</u> is required to see a <u>Network Specialist</u>	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common	Services You May		What You Will Pay		Limitations, Exceptions, & Other Important
Medical Event	Need	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)	Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	\$30 <u>copay</u> per visit	Not Covered	Virtual visits – \$25 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> If you receive services in addition to office visit, additional <u>copays</u> or <u>coinsurance</u> may apply e.g. surgery. Cost-sharing waived at non-IHCP with IHCP <u>referral</u> .
	<u>Specialist</u> visit	No Charge	\$65 <u>copay</u> per visit	Not Covered	If you receive services in addition to office visit, additional <u>copays</u> or <u>coinsurance</u> may apply e.g. surgery. Cost-sharing waived at non-IHCP with IHCP <u>referral</u> .
	Preventive care/screening/ immunization	No Charge	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Lab Testing: \$65 <u>copay</u> per service X-Ray/Diagnostic: \$75 <u>copay</u> per service	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.
	Imaging (CT/PET scans, MRIs)	No Charge	\$175 <u>copay</u> per service	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.

Common Medical Event	Services You May Need	Indian Health	What You Will Pay Non-IHCP In-	Non-IHCP Out-of-	Limitations, Exceptions, & Other Important Information
		Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay more)	Network Provider (You will pay the most)	
If you need drugs to treat your illness or	Tier 1 – Your Lowest Cost Option	No Charge	\$15 <u>copay,</u> <u>deductible</u> 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 2.5x the 30-day
More information	Tier 2 – Your Mid- Range Cost Option	No Charge	\$40 <u>copay,</u> <u>deductible</u> does not apply.	Not Covered	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
about prescription drug coverage is available at	Tier 3 – Your Mid- Range Cost Option	No Charge	\$75 <u>copay,</u> <u>deductible</u> does not apply.	Not Covered	preauthorization, benefits will not be covered. Certain preventive medications (including certain contraceptives) are covered at No Charge, <u>Deductible</u>
uhc.com/xnydruglist 2024	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	Not Applicable	does not apply. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. Cost-sharing waived at non-IHCP with IHCP <u>referral</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	\$150 <u>copay</u> per service	Not Covered	Referral is only required if referred by a specialist. Cost-sharing waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No Charge	30% coinsurance	Not Covered	Referral is only required if referred by a specialist. Cost-sharing waived at non-IHCP with IHCP referral.
If you need immediate medical	Emergency room care	No Charge	\$500 <u>copay</u> per visit	\$350 <u>copay</u> per visit	Cost-sharing waived at non-IHCP with IHCP referral.
attention	Emergency medical transportation	No Charge	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Cost-sharing waived at non-IHCP with IHCP referral.
	<u>Urgent care</u>	No Charge	\$70 <u>copay</u> per visit	Not Covered	If you receive services in addition to <u>Urgent care</u> visit, additional <u>copays</u> , or <u>coinsurance</u> may apply e.g. surgery. Cost-sharing waived at non-IHCP with IHCP <u>referral</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	\$1,500 <u>copay</u> per admission	Not Covered	Referral is only required if referred by a specialist. Cost-sharing waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No Charge	30% coinsurance	Not Covered	Referral is only required if referred by a specialist. Cost-sharing waived at non-IHCP with IHCP referral.

Common	Services You May		What You Will Pay		Limitations, Exceptions, & Other Important
Medical Event	Need	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)	Information
If you need mental health, behavioral health, or	Outpatient services	No Charge	\$30 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Network Partial hospitalization/intensive outpatient treatment: \$30 copay per visit Cost-sharing waived at non-IHCP with IHCP referral.
substance abuse services	Inpatient services	No Charge	\$1,500 <u>copay</u> per admission	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.
If you are	Office visits	No Charge	No Charge	Not Covered	Cost sharing does not apply for preventive services.
pregnant	Childbirth/delivery professional services	No Charge	30% coinsurance	Not Covered	Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> 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 <u>referral</u> .
	Childbirth/delivery facility services	No Charge	\$1,500 <u>copay</u> per admission	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.
If you need help recovering or have	Home health care	No Charge	30% coinsurance	Not Covered	Limited to 40 visits per calendar year. Cost-sharing waived at non-IHCP with IHCP referral.
other special health needs	Rehabilitation services	No Charge	\$30 <u>copay</u> per visit	Not Covered	Limits per condition per calendar year: Physical/Occupational/ Speech: combined limit 60 visits; Cardiac: Unlimited; Pulmonary: Unlimited. Cost-sharing waived at non-IHCP with IHCP referral.
	Habilitative services	No Charge	\$30 <u>copay</u> per visit	Not Covered	Limits per condition per calendar year: Physical/Occupational/ Speech: combined limit 60 visits Cost-sharing waived at non-IHCP with IHCP referral.
	Skilled nursing care	No Charge	\$1,500 <u>copay</u> per admission	Not Covered	Skilled Nursing is limited to 200 days per calendar year. Inpatient rehabilitation limited to 60 days. Cost-sharing waived at non-IHCP with IHCP referral.
	<u>Durable medical</u> <u>equipment</u>	No Charge	30% coinsurance	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.
	Hospice services	No Charge	30% coinsurance	Not Covered	Limited to 210 days per calendar year. Cost-sharing waived at non-IHCP with IHCP referral.
If your child needs dental or eye care	Children's eye exam	No Charge	\$30 copayment	Not Covered	Limited to 1 exam every 12 months. Cost-sharing waived at non-IHCP with IHCP referral.

Common	Services You May		What You Will Pay		Limitations, Exceptions, & Other Important
Medical Event	Need	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)	Information
		No Charge	30% <u>coinsurance</u>	Not Covered	Limited to 1 pair every 12 months. You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Cost-sharing waived at non-IHCP with IHCP referral.
	Children's dental check- up	No Charge	\$30 <u>copayment</u>	Not Covered	Cleanings are covered 1 time every 6 months. Additional limitations may apply. Cost-sharing waived at non-IHCP with IHCP referral.

Excluded Services & Other Covered Services:

Se	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	•	Long-term care	•	Routine eye care (adult)				
•	Cosmetic surgery	•	Non-emergency care when travelling outside -	•	Routine foot care – Except as covered for				
•	Dental care (adult)		the U.S.		Diabetes				
•	Glasses (adult)	•	Private duty nursing	•	Weight loss programs				

(Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)							
	 Abortion 	•	Chiropractic (Manipulative care)	•	Infertility treatment			
	Bariatric surgery	•	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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <a href="doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/doi:10.50/d

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 Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or New York Department of Financial Services at 1-800-342-3736 or dfs.ny.gov/index.html.

Additionally, a consumer assistance program may help you file your appeal. Contact Massachusetts Division of Insurance at 1-617-521-7794 or mass.gov/ocabr/government/oca- agencies/doi-lp.

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 1-877-856-2429.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-856-2429.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-856-2429.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-856-2429.

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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in- <u>network</u> pre-natal care and a hospital delivery)		Managing Joe's type 2 Diak (a year of routine in- <u>network</u> care o controlled condition)		Mia's Simple Fractory (in- <u>network</u> emergency room follow up care)	
 The plan's overall deductible Specialist copay Hospital (facility) copay Other coinsurance \$2,100 \$65 \$1,500 30% 		 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copay</u> Hospital (facility) <u>copay</u> Other <u>coinsurance</u> 	\$2,100 \$65 \$1,500 30%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copay</u> Hospital (facility) <u>copay</u> Other <u>coinsurance</u> 	\$2,100 \$65 \$1,500 30%
This EXAMPLE event includes services Specialist office visits (pre-natal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood w Specialist visit (anesthesia)	-	This EXAMPLE event includes service Primary care physician office visits (includeducation) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose medical)	ding disease	This EXAMPLE event includes serv Emergency room care (including medical possible medical equipment (crutches) Rehabilitation services (physical thera	ical supplies))
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	
<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0	<u>Copayments</u>	\$0	<u>Copayments</u>	\$0
Coinsurance	\$0	<u>Coinsurance</u>	<u>Coinsurance</u> \$0 <u>Coinsurance</u>		
What isn't covered		What isn't covered	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 patien	nt received o	are from an IHCP <u>provider</u> or with IHCP <u>re</u>	<u>ferral</u> at a nor	-IHCP. If you receive care from a non-II	HCP

provider without a referral from an IHCP your costs may be higher.