



 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 1-877-482-9045 or visit [uhc.com/aca-sample-policy](http://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/](http://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 <a href="http://uhc.com/xazdocfindg2024">uhc.com/xazdocfindg2024</a> or call 1-877-482-9045 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 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	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 Provider (You will pay the most)	
	<u>Specialist visit</u>	No Charge	No Charge	None
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	No Charge	None
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	None
<b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://uhc.com/xazdruglist2024">uhc.com/xazdruglist2024</a>	Tier 1 - Your Lowest Cost Option	No Charge	No Charge	<u>Provider</u> means pharmacy for purposes of this section. Retail: One month supply up to a 30-day supply or a 90-day supply at 2.5x the 30-day <u>cost share</u> . Mail-Order: Up to a 90-day supply at 2.5x the 30-day <u>cost share</u> . Specialty drugs limited to a 30-day supply at a <u>network pharmacy</u> . 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. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered.
	Tier 2 - Your Lower Cost Option	No Charge	No Charge	
	Tier 3 - Your Mid-Range Cost Option	No Charge	No Charge	
	Tier 4 - Your Mid-Range Cost Option	No Charge	No Charge	
	Tier 5 - Your Higher Cost Option	No Charge	No Charge	
	Tier 6 - Your Highest Cost Option	No Charge	No Charge	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	None
	Physician/surgeon fees	No Charge	No Charge	None
<b>If you need immediate medical attention</b>	<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	Virtual visits - No Charge by a Designated Virtual <u>Provider</u> .
<b>If you have a hospital stay</b>	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 Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visit: No Charge Outpatient: No Charge	Office Visit: No Charge Outpatient: No Charge	None
	Inpatient services	No Charge	No Charge	None
<b>If you are pregnant</b>	Office visits	No Charge	No Charge	None
	Childbirth/delivery professional services	No Charge	No Charge	
	Childbirth/delivery facility services	No Charge	No Charge	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No Charge	No Charge	Limited to 42 visits/year. This limit does not apply to <u>home health care</u> services that are provided instead of an inpatient stay.
	<u>Rehabilitation services</u>	No Charge	No Charge	Limits/year: Occupational, Physical, Speech: combined limit 60 visits; Cardiac, Pulmonary: Unlimited visits each
	<u>Habilitative services</u>	No Charge	No Charge	Limits/year: Occupational, Physical, Speech: combined limit 60 visits; No limits apply for treatment of Autism Spectrum Disorder or covered mental health or substance use disorders.
	<u>Skilled nursing care</u>	No Charge	No Charge	Limited to 90 days/year (combined with inpatient rehabilitation)
	<u>Durable medical equipment</u>	No Charge	No Charge	None
	<u>Hospice services</u>	No Charge	No Charge	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	No Charge	Limited to 1 exam/12 months.
	Children's glasses	No Charge	No Charge	Limited to 1 pair/12 months.
	Children's dental check-up	No Charge	No Charge	Limited to 2 visits/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 - (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 plan document.)

- Bariatric surgery
- Chiropractic (manipulative) care - 20 visits/year
- Dental care (Adult) - 2 visits/12 months
- Glasses (Adult) - 1 pair/12 months
- Hearing aids
- Private duty nursing - inpatient only
- Routine eye care (Adult) - 1 exam/12 months

**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 Arizona, Inc. at 1-877-482-9045 or 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](https://dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa) or Arizona Department of Insurance, 100 N. 15th Avenue, Suite 261, Phoenix, AZ 85007-2630, Toll free: 1-800-325-2548, Spanish: 1-602-364-2977 or [id.state.az.us](https://id.state.az.us) or Office of Personnel Management Multi State Plan Program: [opm.gov/healthcare-insurance/multi-state-plan-program/external-review/](https://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 [HealthCare.gov](https://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 Member Service number listed on the back of your ID card or [myuhc.com/exchange](https://myuhc.com/exchange) or the Employee Benefits Security Administration at 1-866-444-3272 or [dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa](https://dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa) or Arizona Department of Insurance at Toll free: 1-800-325-2548, Spanish: 1-602-364-2977 or [id.state.az.us](https://id.state.az.us).

Additionally, a consumer assistance program may help you file your appeal. Contact [dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa](https://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 1-877-482-9045

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-482-9045

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-482-9045

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-482-9045

*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)

■ <b>The plan's overall deductible</b>	<b>\$0</b>
■ <b>Specialist copayment</b>	<b>\$0</b>
■ <b>Hospital (facility) coinsurance</b>	<b>0%</b>
■ <b>Other coinsurance</b>	<b>0%</b>

**Managing Joe's Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

■ <b>The plan's overall deductible</b>	<b>\$0</b>
■ <b>Specialist copayment</b>	<b>\$0</b>
■ <b>Hospital (facility) coinsurance</b>	<b>0%</b>
■ <b>Other coinsurance</b>	<b>0%</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

■ <b>The plan's overall deductible</b>	<b>\$0</b>
■ <b>Specialist copayment</b>	<b>\$0</b>
■ <b>Hospital (facility) coinsurance</b>	<b>0%</b>
■ <b>Other coinsurance</b>	<b>0%</b>

**This EXAMPLE event includes services like:**

- Specialist office visits (*pre-natal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

**This EXAMPLE event includes services like:**

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

**This EXAMPLE event includes services like:**

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
<u>Deductibles</u>	<b>\$0</b>
<u>Copayments</u>	<b>\$0</b>
<u>Coinsurance</u>	<b>\$0</b>
<i>What isn't covered</i>	
Limits or exclusions	<b>\$60</b>
<b>The total Peg would pay is</b>	<b>\$60</b>

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
<u>Deductibles</u>	<b>\$0</b>
<u>Copayments</u>	<b>\$0</b>
<u>Coinsurance</u>	<b>\$0</b>
<i>What isn't covered</i>	
Limits or exclusions	<b>\$0</b>
<b>The total Joe would pay is</b>	<b>\$0</b>

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
<u>Deductibles</u>	<b>\$0</b>
<u>Copayments</u>	<b>\$0</b>
<u>Coinsurance</u>	<b>\$0</b>
<i>What isn't covered</i>	
Limits or exclusions	<b>\$0</b>
<b>The total Mia would pay is</b>	<b>\$0</b>