
 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 1-877-940-4172 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? | No | You will have to meet the deductible before the plan pays for any services. |
| Are there other deductibles for specific services? | Yes, Prescription drugs - \$2,500 Individual / \$5,000 Family Deductible does not apply to Tier 1, Tier 2 and Tier 3 drugs. There are no other deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | Network: \$9,450 Individual / \$18,900 Family | 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, and 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/xmodocfindoa2024 or call 1-877-940-4172 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 |
|-----------------------|-----------------------------|---|---|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health | Primary care visit to treat | No Charge | Not Covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| care provider's office or clinic | an injury or illness | | | |
| | <u>Specialist visit</u> | \$100 <u>copay</u> /visit, <u>deductible</u> does not apply | Not Covered | None |
| | <u>Preventive care/ screening/ immunization</u> | 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 | <u>Diagnostic test</u> (x-ray, blood work) | Lab Testing: Free Standing/Office: \$20 <u>copay</u> /service, <u>deductible</u> does not apply Hospital: \$120 <u>copay</u> /service, <u>deductible</u> does not apply X-Ray/Diagnostics: Free Standing/Office: \$65 <u>copay</u> /service, <u>deductible</u> does not apply Hospital: \$120 <u>copay</u> /service, <u>deductible</u> does not apply | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | Free Standing/Office: \$300 <u>copay</u> /service, <u>deductible</u> does not apply Hospital: \$600 <u>copay</u> /service, <u>deductible</u> does not apply | Not Covered | None |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at uhc.com/xmodruglist2024 | Tier 1 - Your Lowest Cost Option | No Charge | Not Covered | <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</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 |
| | Tier 2 – Your Lower Cost Option | \$5 <u>copay</u> /prescription, <u>deductible</u> does not apply | Not Covered | |
| | Tier 3 - Your Mid-Range Cost Option | \$30 <u>copay</u> /prescription, <u>deductible</u> does not apply | Not Covered | |
| | Tier 4 – Your Mid-Range Cost Option | \$85 <u>copay</u> /prescription | Not Covered | |
| | Tier 5 – Your Higher Cost | 40% <u>coinsurance</u> | Not Covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Option | | | covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. |
| | Tier 6 – Your Highest Cost Option | 50% <u>coinsurance</u> | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$750 <u>copay</u> /service, <u>deductible</u> does not apply | Not Covered | None |
| | Physician/surgeon fees | Free Standing/Office: \$750 <u>copay</u> /service, <u>deductible</u> does not apply Hospital: \$1,500 <u>copay</u> /service, <u>deductible</u> does not apply | Not Covered | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$1,500 <u>copay</u> /visit, <u>deductible</u> does not apply | \$1,500 <u>copay</u> /visit, <u>deductible</u> does not apply | None |
| | <u>Emergency medical transportation</u> | 30% <u>coinsurance</u> , <u>deductible</u> does not apply | 30% <u>coinsurance</u> , <u>deductible</u> does not apply | None |
| | <u>Urgent care</u> | \$75 <u>copay</u> /visit, <u>deductible</u> does not apply | Not Covered | Virtual visits - No Charge by a Designated Virtual <u>Provider</u> . |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$2,500 <u>copay</u> /day up to 3 days /admission, <u>deductible</u> does not apply | Not Covered | None |
| | Physician/surgeon fees | 30% <u>coinsurance</u> , <u>deductible</u> does not apply | Not Covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit: \$100 <u>copay</u> /visit, <u>deductible</u> does not apply Outpatient: \$750 <u>copay</u> /visit, <u>deductible</u> does not apply | Not Covered | None |
| | Inpatient services | \$2,500 <u>copay</u> /day up to 3 days /admission, <u>deductible</u> does not apply | Not Covered | None |
| If you are pregnant | Office visits | No Charge | Not Covered | <u>Cost-sharing</u> does not apply for <u>preventive services</u> . |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Childbirth/delivery professional services | 30% <u>coinsurance</u> , <u>deductible</u> does not apply | 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.) |
| | Childbirth/delivery facility services | \$2,500 <u>copay</u> /day up to 3 days /admission, <u>deductible</u> does not apply | Not Covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 30% <u>coinsurance</u> , <u>deductible</u> does not apply | Not Covered | Limited to 100 visits/year |
| | <u>Rehabilitation services</u> | \$100 <u>copay</u> /visit, <u>deductible</u> does not apply | Not Covered | Limits/year: Physical, Occupational: 20 visits each; Speech, Pulmonary: Unlimited visits each; Cardiac: 36 visits |
| | <u>Habilitative services</u> | \$100 <u>copay</u> /visit, <u>deductible</u> does not apply | Not Covered | Limits/year: Physical, Occupational: 20 visits each; Speech: Unlimited visits No limits apply for treatment of Autism Spectrum Disorder Services. |
| | <u>Skilled nursing care</u> | \$2,500 <u>copay</u> /day up to 3 days /admission, <u>deductible</u> does not apply | Not Covered | Limited to 150 days/year (combined with inpatient rehabilitation) |
| | <u>Durable medical equipment</u> | 30% <u>coinsurance</u> , <u>deductible</u> does not apply | Not Covered | None |
| | <u>Hospice services</u> | 30% <u>coinsurance</u> , <u>deductible</u> does not apply | Not Covered | None |
| If your child needs dental or eye care | Children's eye exam | No Charge | Not Covered | Limited to 1 exam/12 months. |
| | Children's glasses | 30% <u>coinsurance</u> , <u>deductible</u> does not apply | Not Covered | Limited to 1 pair/12 months. |
| | Children's dental check-up | No Charge | Not Covered | 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) | • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. |
| • 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 - 1 purchase per hearing impaired ear/48 months | • Private duty nursing - 82 visits/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 1-877-940-4172 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 or Missouri Department of Insurance, 301 W. High St., Room 630, Jefferson City, MO 65101, 1-855-373-4636, Relay Missouri: 711 or mydss.mo.gov/healthcare 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 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 or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or Missouri Department of Insurance at 1-855-373-4636, Relay Missouri: 711 or mydss.mo.gov/healthcare .

Additionally, a consumer assistance program may help you file your appeal. Contact 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 1-877-940-4172

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-940-4172

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-940-4172

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-940-4172

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)

| | |
|--|----------------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$100 |
| ■ Hospital (facility) copayment | \$2,500 |
| ■ Other coinsurance | 30% |

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*)

| | |
|--|-----------------|
| Total Example Cost | \$12,700 |
| In this example, Peg would pay: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$3,500 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,560 |

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

| | |
|--|----------------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$100 |
| ■ Hospital (facility) copayment | \$2,500 |
| ■ Other coinsurance | 30% |

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*)

| | |
|--|----------------|
| Total Example Cost | \$5,600 |
| In this example, Joe would pay: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$1,800 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,800 |

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

| | |
|--|----------------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$100 |
| ■ Hospital (facility) copayment | \$2,500 |
| ■ Other coinsurance | 30% |

This **EXAMPLE** event includes services like:

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

| | |
|--|----------------|
| Total Example Cost | \$2,800 |
| In this example, Mia would pay: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$1,600 |
| <u>Coinsurance</u> | \$300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,900 |

Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.