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?	Network: $150 Individual / $300 Family	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. Benefits available with no charge such as Network Preventive care services are covered before you meet your deductible. The cost-sharing below indicates whether the deductible applies for each benefit	This plan covers some items and services even if you haven't yet met the 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 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: $1,500 Individual / $3,000 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/xmodocfindoa2025 or call 1-866-761-7748 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 care provider's office or clinic	Primary care visit to treat an injury or illness	$1 copay /visit, deductible does not apply	Not Covered	None
	Specialist visit	$10 copay /visit, deductible does not apply	Not Covered	None
	Preventive care/ screening/ immunization	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)	Lab Testing: Free Standing/Office: $1 copay /service Hospital: $20 copay /service X-Ray/Diagnostics: Free Standing/Office: $5 copay /service Hospital: $30 copay /service	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: $10 copay /service Hospital: $50 copay /service	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at uhc.com/xmodruglist2025	Tier 1 - $0 Cost-share	No Charge	Not Covered	Provider 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 cost-share. Mail-Order: Up to a 90-day supply at 2.5x the 30-day cost-share. Specialty drugs limited to a 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. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Insulin products listed on the Prescription Drug List are covered at No Charge at a network pharmacy.
	Tier 2 – Preferred Generic	$1 copay /prescription, deductible does not apply	Not Covered	
	Tier 3 - Preferred Brand	$30 copay /prescription	Not Covered	
	Tier 4 – Non-Preferred Brand	40% coinsurance	Not Covered	
	Tier 5 - Specialty	50% coinsurance	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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$30 copay /service	Not Covered	None
	Physician/surgeon fees	Free Standing/Office: $30 copay /date of service Hospital: $60 copay /date of service	Not Covered	None
If you need immediate medical attention	Emergency room care	$150 copay /visit	$150 copay /visit	None
	Emergency medical transportation	$150 copay /transport	$150 copay /transport	None
	Urgent care	$50 copay /visit, deductible does not apply	Not Covered	Virtual visits - No Charge by a Designated Virtual Network Provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	Not Covered	None
	Physician/surgeon fees	5% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $1 copay /visit, deductible does not apply Intensive Outpatient: $20 copay /visit All Other Outpatient: $30 copay /visit	Not Covered	None
	Inpatient services	5% coinsurance	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost-sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	5% coinsurance	Not Covered	
	Childbirth/delivery facility services	5% coinsurance	Not Covered	
If you need help recovering or have	Home health care	5% coinsurance	Not Covered	Limited to 100 visits/year
	Rehabilitation services	$1 copay /visit, deductible	Not Covered	Limits/year: Cardiac: 36 visits; Physical, Occupational:

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)	
other special health needs		does not apply		20 visits each; Speech, Pulmonary: Unlimited visits each
	Habilitative services	$1 copay /visit, deductible does not apply	Not Covered	Limits/year: Speech: Unlimited visits; Physical, Occupational: 20 visits each No limits apply for treatment of Autism Spectrum Disorder Services.
	Skilled nursing care	5% coinsurance	Not Covered	Limited to 150 days/year (combined with inpatient rehabilitation)
	Durable medical equipment	5% coinsurance	Not Covered	None
	Hospice services	5% coinsurance	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	5% coinsurance	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) • Acupuncture • Bariatric surgery	• Cosmetic surgery • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Routine foot care - except as covered for certain diseases • 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 • Dental care (Adult) - 2 visits/12 months	• Hearing aids - 1 purchase per hearing impaired ear/48 months • Private-duty nursing - 82 visits /year	• 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 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, kwiijigo 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	$150
Specialist copayment	$10
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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:	
Cost Sharing	
Deductibles	$150
Copayments	$40
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$650**

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

The plan's overall deductible	$150
Specialist copayment	$10
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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:	
Cost Sharing	
Deductibles	$150
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$240**

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

The plan's overall deductible	$150
Specialist copayment	$10
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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:	
Cost Sharing	
Deductibles	$150
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**