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 1-888-832-0969 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 - $1,500 Individual / $3,000 Family Deductible does not apply to Generic 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: $7,850 Individual / $15,700 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/xwadocfindg2024 or call 1-888-832-0969 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.

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	Primary care visit to treat an injury or illness	$20 copay /visit, deductible does not apply	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)	
or clinic	Specialist visit	$50 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: $20 copay /service, deductible does not apply Hospital: $120 copay /service, deductible does not apply X-Ray/Diagnostics: Free Standing/Office: $65 copay /service, deductible does not apply Hospital: $120 copay /service, deductible does not apply	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: $275 copay /service, deductible does not apply Hospital: $600 copay /service, deductible does not apply	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at uhc.com/xwadruglist2024	Generic Drugs	$30 copay /prescription, deductible does not apply	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.
	Preferred Brand Drgus	$85 copay /prescription	Not Covered	
	Non-Preferred Brand Drugs	50% coinsurance	Not Covered	
	Specialty Drugs	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)	
				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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$750 copay /service, deductible does not apply	Not Covered	None
	Physician/surgeon fees	Free Standing/Office: $750 copay /service, deductible does not apply Hospital: $1,500 copay /service, deductible does not apply	Not Covered	None
If you need immediate medical attention	Emergency room care	$1,500 copay /visit, deductible does not apply	$1,500 copay /visit, deductible does not apply	None
	Emergency medical transportation	30% coinsurance, deductible does not apply	30% coinsurance, deductible does not apply	None
	Urgent care	$75 copay /visit, deductible does not apply	Not Covered	Virtual visits - No Charge by a Designated Virtual Provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	$2,500 copay /day up to 3 days /admission, deductible does not apply	Not Covered	None
	Physician/surgeon fees	30% coinsurance, deductible does not apply	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $50 copay /visit, deductible does not apply Outpatient: $750 copay /visit, deductible does not apply	Not Covered	None
	Inpatient services	$2,500 copay /day up to 3 days /admission, deductible does not apply	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
	Childbirth/delivery professional services	30% coinsurance, deductible	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)	
		does not apply		services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	$2,500 copay /day up to 3 days /admission, deductible does not apply	Not Covered	
If you need help recovering or have other special health needs	Home health care	30% coinsurance, deductible does not apply	Not Covered	Limited to 130 visits/year.
	Rehabilitation services	Outpatient: $50 copay /visit, deductible does not apply Inpatient: $2,500 copay /day up to 3 days /admission, deductible does not apply	Not Covered	Limits/year: Occupational, Physical, Speech: combined limit 25 visits; Cardiac, Pulmonary: Unlimited visits each Inpatient rehabilitation and habilitative services limited to 30 days/year. No limits apply for covered Neurodevelopmental therapy or therapies for cancer or other similar chronic conditions.
	Habilitative services	Outpatient: $50 copay /visit, deductible does not apply Inpatient: $2,500 copay /day up to 3 days /admission, deductible does not apply	Not Covered	Limits/year: Occupational, Physical, Speech: combined limit 25 visits; Inpatient rehabilitation and habilitative services limited to 30 days/year. No limits apply for treatment of covered mental disorders.
	Skilled nursing care	$2,500 copay /day up to 3 days /admission, deductible does not apply	Not Covered	Skilled Nursing is limited to 60 days/year.
	Durable medical equipment	30% coinsurance, deductible does not apply	Not Covered	None
	Hospice services	30% coinsurance, deductible does not apply	Not Covered	Respite care limited to 14 days/lifetime.
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	No Charge	Not Covered	Limited to 1 pair/12 months.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up

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.)		
• Bariatric surgery	• Hearing aids	• Private duty nursing
• Cosmetic surgery	• Infertility treatment	• Routine eye care (Adult)
• Dental care (Adult)	• Long-term care	• Routine foot care - except as covered for diabetes
• Glasses (Adult)	• Non-emergency care when traveling outside the U.S.	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion	• Acupuncture - 12 visits/year	• Chiropractic (manipulative) care - 10 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 of Oregon, Inc. at 1-888-832-0969 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 Washington State Office of the Insurance Commissioner, 5000 Capitol Blvd., SE, Tumwater, WA 98501, 1-800-562-6900 or insurance.wa.gov or osi.state.nm.us 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 Washington State Office of the Insurance Commissioner at 1-800-562-6900 or insurance.wa.gov .

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 1-888-832-0969
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-832-0969
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-832-0969
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-832-0969

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	$50
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:	
Cost Sharing	
Deductibles	$0
Copayments	$3,500
Coinsurance	$0
What isn't covered	
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	$50
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:	
Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$800

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

The plan's overall deductible	$0
Specialist copayment	$50
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:	
Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,700

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

UnitedHealthcare of Oregon, Inc., on behalf of itself and its affiliated companies complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual identity. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

UnitedHealthcare provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member phone number listed on your health plan ID card or 1-888-383-9253, TTY 711.

1	Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
2	Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
3	Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu đư c thông dịch viên giúp đỡ, vui lòng gọi s đi n tho i mi n phí dành cho h i viên đư c nêu trên th ID chương trình b o hi m y t c a quý v , bấm số 0. TTY 711
4	Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
5	Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
6	Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
7	Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
8	Mon-Khmer, Cambodian	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711

9	Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
10	Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
11	Cushite	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
12	Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
13	Panjabi	| 711 , 0 |
14	German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
15	Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັ ບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711

If you believe that the UnitedHealthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation you can file a grievance in writing by mail or email. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy. A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UT 84130

UHC_Civil_Rights@uhc.com

If you need help with your complaint, please call the toll-free number on your health plan ID card, TTY 711.

You can also file a civil rights complaint directly with:

The *U.S. Department of Health and Human Services* online, by phone or mail:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-868-1019, 800-537-7697 (TDD)

Mail: *U.S. Department of Health and Human Services*. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

The Washington State Office of the Insurance Commissioner online or by phone:

Online: https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status

Complaint forms are available at
https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx

Phone: 1-800-562-6900 or (360) 586-0241 (TDD)