



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](https://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/](https://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 <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	No	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
Are there other <u>deductibles</u> for specific services?	Yes, <u>Prescription drugs</u> - \$500 Individual / \$1,000 Family <u>Deductible</u> does not apply to Tier 1, Tier 2, Tier 3 and Tier 4 drugs. There are no other <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>Network</u> : \$7,000 Individual / \$14,000 Family	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 <u>out-of-pocket limit</u> ?	Premiums, <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 <a href="https://uhc.com/xmodocfindoa2024">uhc.com/xmodocfindoa2024</a> or call 1-877-940-4172 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 charge</u> 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> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No Charge	Not Covered	None
	<u>Specialist</u> visit	\$75 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	None
	<u>Preventive care/ screening/</u> immunization	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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Lab Testing: Free Standing/Office: \$10 <u>copay</u> /service, <u>deductible</u> does not apply Hospital: \$65 <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: \$100 <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
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://uhc.com/xmodruglist2024">uhc.com/xmodruglist2024</a>	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	\$3 <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	\$50 <u>copay</u> /prescription, <u>deductible</u> does not apply	Not Covered	
	Tier 5 – Your Higher Cost	45% <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	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$300 <u>copay</u> /service, <u>deductible</u> does not apply	Not Covered	None
	Physician/surgeon fees	Free Standing/Office: \$300 <u>copay</u> /service, <u>deductible</u> does not apply Hospital: \$450 <u>copay</u> /service, <u>deductible</u> does not apply	Not Covered	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$500 <u>copay</u> /visit, <u>deductible</u> does not apply	\$500 <u>copay</u> /visit, <u>deductible</u> does not apply	None
	<u>Emergency medical transportation</u>	45% <u>coinsurance</u> , <u>deductible</u> does not apply	45% <u>coinsurance</u> , <u>deductible</u> does not apply	None
	<u>Urgent care</u>	\$50 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	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)	\$2,000 <u>copay</u> /day up to 3 days /admission, <u>deductible</u> does not apply	Not Covered	None
	Physician/surgeon fees	45% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visit: \$75 <u>copay</u> /visit, <u>deductible</u> does not apply Outpatient: \$300 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	None
	Inpatient services	\$2,000 <u>copay</u> /day up to 3 days /admission, <u>deductible</u> does not apply	Not Covered	None
<b>If you are pregnant</b>	Office visits	No Charge	Not Covered	<u>Cost-sharing</u> does not apply for <u>preventive services</u> . 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
	Childbirth/delivery professional services	45% <u>coinsurance</u> , <u>deductible</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)	
		does not apply		services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	\$2,000 <u>copay</u> /day up to 3 days /admission, <u>deductible</u> does not apply	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	45% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	Limited to 100 visits/year
	<u>Rehabilitation services</u>	\$75 <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>	\$75 <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>	\$2,000 <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>	45% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	None
	<u>Hospice services</u>	45% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered	Limited to 1 exam/12 months.
	Children's glasses	45% <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](https://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](https://mydss.mo.gov/healthcare) 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 Missouri Department of Insurance at 1-855-373-4636, Relay Missouri: 711 or [mydss.mo.gov/healthcare](https://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](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 1-877-940-4172

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	\$75
■ Hospital (facility) copayment	\$2,000
■ Other coinsurance	45%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
In this example, Peg would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$2,400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,460</b>

### 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	\$75
■ Hospital (facility) copayment	\$2,000
■ Other coinsurance	45%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
In this example, Joe would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,200</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$75
■ Hospital (facility) copayment	\$2,000
■ Other coinsurance	45%

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>\$2,800</b>
In this example, Mia would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>

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