Coverage Period: 01/01/2026 - 12/31/2026

Coverage for: Family | Plan Type: PS1

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 1-866-633-2446.or visit welcometouhc.com. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary/</u> or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$275 Individual / \$550 Family Out-of-Network: \$550 Individual / \$1,100 Family Per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and categories with a <u>copay</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Network: \$1,500 Individual / \$3,000 Family Out-of-Network: \$3,000 Individual / \$6,000 Family Per calendar year.	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, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>myuhc.com</u> or call 1-866-633-2446 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</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an out-of- <u>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 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	Services You May Need	What You Will Pay		Limitations Expansions & Other Important	
Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply.	30% <u>coinsurance</u>	Virtual visits - \$20 copay per visit, by a Designated Virtual Network Provider, deductible does not apply. Office Visit cost share applies to any other Telehealth service based on provider type. No virtual coverage out-of-network. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.	
	Specialist visit	\$30 <u>copay</u> per visit, <u>deductible</u> does not apply.	30% coinsurance	If you receive services in addition to office visit, additional <u>copay</u> s, <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.	
	Preventive care/screening/ 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. No coverage out-of- <u>network</u> .	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	30% <u>coinsurance</u>	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.	
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% coinsurance	<u>Preauthorization</u> is required out-of-network or benefit reduces to 50% of allowed amount.	

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>welcometouhc.com</u>.

Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event		Network Provider	Out-of-Network Provider	Information	
Micalcal Evelit	Noou	(You will pay the least)	(You will pay the most)	Information	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Tier 1 – Your Lowest Cost Option	Retail: \$10 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$20 <u>copay</u> , <u>deductible</u> does not apply.	Not Covered		
	Tier 2 – Your Mid-Range Cost Option	Retail: \$20 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: 20% <u>coinsurance</u> with a \$50 <u>copay</u> , <u>deductible</u> does not apply.	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order*: Up to a 90 day supply. Pharmacy out-of-pocket limit: \$3,000 Ind / \$6,000 Fam.	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$30 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: 30% <u>coinsurance</u> with a \$75 <u>copay</u> , <u>deductible</u> does not apply.	Not Covered		
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required out-of- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .	
, ,	Physician/surgeon fees	10% coinsurance	30% coinsurance	None	
If you need immediate medical attention	Emergency room care	\$75 <u>copay</u> per visit, <u>deductible</u> does not apply.	\$75 <u>copay</u> per visit, <u>deductible</u> does not apply.	None	
	Emergency medical transportation	10% coinsurance	*10% coinsurance	* <u>Network</u> <u>deductible</u> applies	
	<u>Urgent care</u>	\$30 <u>copay</u> per visit, <u>deductible</u> does not apply.	30% <u>coinsurance</u>	None	

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>welcometouhc.com</u>.

Common	Camilaga Vay May	What You Will Pay		Limitations Expensions & Other Important	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.	
Stay	Physician/surgeon fees	10% coinsurance	30% coinsurance	None	
If you need mental health, behavioral health, or substance	Outpatient services	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply.	30% <u>coinsurance</u>	Network Partial hospitalization/intensive outpatient treatment: 10% coinsurance. Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.	
abuse services	Inpatient services	10% <u>coinsurance</u>	30% coinsurance	<u>Preauthorization</u> is required out-of- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .	
	Office visits	No Charge	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service a copayment,	
If you are pregnant	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Inpatient preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.	
If you need help recovering or have other special health needs	Home health care	10% <u>coinsurance</u>	30% coinsurance	Limited to 60 visits per calendar year. <u>Preauthorization</u> is required out-of-network or benefit reduces to 50% of allowed amount.	
	Rehabilitation services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Any combination of outpatient rehabilitation services is limited to 90 visits per calendar year. Preauthorization required out-of-network for certain services or benefit reduces to 50% of allowed amount.	
	Habilitative services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Services are provided under and limits are combined with Rehabilitation Services above. Preauthorization required out-of-network for certain services or benefit reduces to 50% of allowed amount.	
	Skilled nursing care	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.	

^{*} For more information about limitations and exceptions, see the $\underline{\mathsf{plan}}$ or policy document at $\underline{\mathsf{welcometouhc.com}}$.

Common	Services You May	What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Need Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
	Durable medical equipment	10% coinsurance	30% <u>coinsurance</u>	Covers 1 per type of DME (including repair/replacement) every 3 years. <u>Preauthorization</u> is required out-of- <u>network</u> for DME over \$1,000 or no coverage.	
	Hospice services	10% coinsurance	30% <u>coinsurance</u>	<u>Preauthorization</u> is required out-of- <u>network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of <u>allowed amount</u> .	
If your child needs dental or eye care	Children's eye exam	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Limited to 1 exam every year. No coverage out-of- <u>network</u> .	
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.	
	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 <u>excluded services</u> .)			
 Acupuncture Bariatric surgery Cosmetic surgery Dental care Glasses 	 Infertility treatment Long-term care Non-emergency care when travelling outside - the U.S. 	 Private duty nursing 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.)					
Chiropractic (Manipulative care) – 50 visits per calendar year	Hearing aids - \$2,500 every 3 years	Routine eye care (adult) - 1 exam per year			

^{*} For more information about limitations and exceptions, see the $\underline{\text{plan}}$ or policy document at $\underline{\text{welcometouhc.com}}$.

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:
U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 www.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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or <u>myuhc.com</u> or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

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? Yes

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 1-866-633-2446.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-633-2446 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2446.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2446.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-633-2446.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>welcometouhc.com</u>.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

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Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in- <u>network</u> emergency room visit and follow up care)	
■ The <u>plan's overall deductible</u> \$275 ■ <u>Specialist copay</u> \$30 ■ Hospital (facility) <u>coinsurance</u> 10% ■ Other <u>coinsurance</u> 10%		 The plan's overall deductible Specialist copay Hospital (facility) coinsurance Other coinsurance 10% 		 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copay</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$275 \$30 10% 10%
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)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
<u>Deductibles</u>	\$250	<u>Deductibles</u>	\$150	<u>Deductibles</u>	\$250
<u>Copayments</u>	\$10	<u>Copayments</u>	\$800	<u>Copayments</u>	\$100
Coinsurance	\$1,000	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$100
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$1,320	The total Joe would pay is	\$950	The total Mia would pay is	\$450