UnitedHealthcare

**PPO Plan**

**Coverage Period: 01/01/2026 – 12/31/2026**

**Coverage for:** Individual/Family | **Plan Type:** PS1

**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 1-888-876-7098.or visit welcometouhc.com. 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: **$750** Individual / **$1,500** Family<br>Out-of-Network: **$1,500** Individual / **$3,000** Family<br>Per calendar year. | 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. Preventive care and categories with a copay are covered before you meet your deductible. | 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 www.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: **$3,500** Individual / **$7,000** Family<br>Out-of-Network: **$7,000** Individual / **$14,000** Family<br>Per calendar year. | 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, 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 out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See myuhc.com or call **1-888-876-7098** for a list of network providers. | You pay the least if you use a provider in the Designated Network. You pay more if you use a provider in the 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 | Designated Network: $25 copay per visit, deductible does not apply. Network: $45 copay per visit, deductible does not apply. | 50% coinsurance | Virtual visits - No Charge by a Designated Virtual Network Provider. 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 | Designated Network: $55 copay per visit, deductible does not apply. Network: $70 copay per visit, deductible does not apply. | 50% coinsurance | If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. |
| | Preventive care/screening/ immunization | No Charge | Only mammograms and PAP covered 50% coinsurance | 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. No coverage out-of-network. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Free Standing/Office: No Charge Hospital: 25% coinsurance | 50% coinsurance | Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. |
| | Imaging (CT/PET scans, MRIs) | Free Standing/Office: 15% coinsurance Hospital: 25% coinsurance | 50% coinsurance | Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |

| 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 need drugs to treat your illness or condition**<br><br>More information about prescription drug coverage is available at welcometouhc.com | Tier 1 – Generic Drugs | Retail: 25% coinsurance but not more than $18/prescription (retail 30 days), 25% coinsurance but not more than $54/prescription (retail 90 days); 25% coinsurance but not more than $42/prescription (home delivery 90 days); 25% coinsurance but not more than $150/prescription (specialty drugs home delivery 30 days) Deductible does not apply<br>Mail-Order: 25% coinsurance with a $42 copay maximum, deductible does not apply | Retail: Not Covered | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 31 day supply.<br>Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy<br>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.<br>Certain drugs may have a preauthorization requirement or may result in a higher cost.<br>If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. 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.<br>You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Pharmacy out-of-pocket limit: $1,500 Ind/ $3,000 Fam. |
| | Tier 2 – Preferred Brand Drugs | Retail: 25% coinsurance but not more than $80/prescription (retail 30 days), 25% coinsurance but not more than $240/prescription (retail 90 days); 25% coinsurance but not more than $160/prescription (home | Retail: Not Covered | |

| | | | |
|---|---|---|---|
| | | delivery 90 days); 30% coinsurance but not more than $175/prescription (specialty drugs home delivery 30 days) Deductible does not apply<br>Mail-Order:<br>25% coinsurance with a $160 copay maximum, deductible does not apply.. | |
| | Tier 3 – Non-Preferred Brand Drugs | Retail:<br>50% coinsurance but not more than $200/prescription (retail 30 days), 50% coinsurance but not more than $600/prescription (retail 90 days); 50% coinsurance but not more than $500/prescription (home delivery 90 days); 50% coinsurance but not more than $325/prescription (specialty drugs home delivery 30 days) Deductible does not apply<br>Mail-Order:<br>25% coinsurance with a $500 copay maximum, deductible does not apply | Retail:<br>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) | Ambulatory Surgical Center/Office: 15% coinsurance Hospital: 25% coinsurance | 50% coinsurance | Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. |
| | Physician/surgeon fees | 15% coinsurance | 50% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $250 copay per visit, deductible does not apply. | $250 copay per visit, deductible does not apply. | None |
| | Emergency medical Transportation | 15% coinsurance | *15% coinsurance | *Network deductible applies |
| | Urgent care | $75 copay per visit, deductible does not apply. | 50% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% coinsurance | 50% coinsurance | Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| | Physician/surgeon fees | 15% coinsurance | 50% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay per visit, deductible does not apply. | 50% coinsurance | Network Partial hospitalization/intensive outpatient treatment: $25 copay per visit, deductible does not apply. Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. |
| | Inpatient services | 15% coinsurance | 50% coinsurance | Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. See your policy or plan document for additional information about EAP benefits. |
| **If you are pregnant** | Office visits | Designated Network: $25 copay per visit, deductible does not apply. Network: $45 copay per visit, deductible does not apply. | 50% coinsurance | 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 | 15% coinsurance | 50% coinsurance | |

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

| 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 facility services | 15% coinsurance | 50% coinsurance | 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 | 15% coinsurance | 50% coinsurance | Limited to 100 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| | Rehabilitation services | Physical Therapy: $40 copay per visit, deductible does not apply All other therapies: $55 copay per visit, deductible does not apply | 50% coinsurance | Limits per calendar year: Physical/Occupational/ Speech and Pulmonary: combined limit 60 visits; Cardiac: 36 visits. |
| | Habilitative services | Physical Therapy: $40 copay per visit, deductible does not apply All other therapies: $55 copay per visit, deductible does not apply | 50% coinsurance | Services are provided under and limits are combined with Rehabilitation Services above. |
| | Skilled nursing care | 15% coinsurance | 50% coinsurance | Limited to 90 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. |
| | Durable medical equipment | 15% coinsurance | 50% coinsurance | Preauthorization is required out-of-network for DME over $1,000 or no coverage. |
| | Hospice services | 15% coinsurance | 50% coinsurance | Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | No coverage for Children's eye exams. |
| | 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 excluded services.) | | |
|---|---|---|
| • Acupuncture<br>• Cosmetic surgery<br>• Dental care<br>• Glasses | • Long-term care<br>• Non-emergency care when travelling outside - the U.S.<br>• Private duty nursing | • Routine eye care<br>• Routine foot care – Except as covered for Diabetes<br>• Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Bariatric surgery<br>• Chiropractic (Manipulative care) – 24 visits per calendar year | • Hearing aids<br>• Infertility treatment | |

**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 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 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 1-888-876-7098.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-888-876-7098.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-876-7098.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-888-876-7098 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-876-7098.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-876-7098.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-876-7098.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-888-876-7098.

***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 plan or policy document at welcometouhc.com.

## 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 | $750 |
| Specialist copay | $70 |
| Hospital (facility) coinsurance | 15% |
| Other coinsurance | 15% |

**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 | $750 |
| Copayments | $10 |
| Coinsurance | $1,600 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,420** |

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

| | |
|---|---|
| The plan's overall deductible | $750 |
| Specialist copay | $70 |
| Hospital (facility) coinsurance | 15% |
| Other coinsurance | 15% |

**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 | $250 |
| Copayments | $1,800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$2,050** |

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

| | |
|---|---|
| The plan's overall deductible | $750 |
| Specialist copay | $70 |
| Hospital (facility) coinsurance | 15% |
| Other coinsurance | 15% |

**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 | $750 |
| Copayments | $500 |
| Coinsurance | $80 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,330** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.