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 1-888-809-6539 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: $7,500 Individual / $15,000 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: $12,000 Individual / $24,000 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/xcodocfindrmv2027 or call 1-888-809-6539 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	$35 copay /visit, deductible does not apply	Not Covered	None
	Specialist visit	$140 copay /visit, deductible does not apply	Not Covered	None
	Preventive care/ screening/ immunization	No Charge, deductible does not apply	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: $30 copay /service, deductible does not apply Hospital: $75 copay /service, deductible does not apply X-Ray/Diagnostics: Free Standing/Office: 45% coinsurance Hospital: 50% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: 45% coinsurance Hospital: 50% coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at uhc.com/xcodruglist2027	Tier 1 – Zero Cost-Share Preventive Drugs	No Charge, 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, deductible does not apply. See the website listed for information on drugs covered
	Tier 2 – Preferred Generic	$30 copay /prescription, deductible does not apply	Not Covered	
	Tier 3 – Preferred Brand	40% coinsurance	Not Covered	
	Tier 4 – Non-Preferred Brand	45% 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)	
				by your plan. Not all drugs are covered. You may obtain up to a 30-day supply of insulin products on Tier 1 at a Network Pharmacy for $0 cost to you.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	45% coinsurance	Not Covered	None
	Physician/surgeon fees	45% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	None
	Emergency medical transportation	50% coinsurance	50% coinsurance	None
	Urgent care	$50 copay /visit, deductible does not apply	$50 copay /visit, deductible does not apply	Virtual visits - No Charge by a Designated Virtual Network Provider, deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	45% coinsurance	Not Covered	None
	Physician/surgeon fees	45% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $35 copay /visit, deductible does not apply Intensive Outpatient: 45% coinsurance Partial Hospitalization: 45% coinsurance All Other Outpatient: 45% coinsurance	Not Covered	None
	Inpatient services	45% coinsurance	Not Covered	None
If you are pregnant	Office visits	No Charge, deductible does not apply	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	45% coinsurance	Not Covered	
	Childbirth/delivery facility services	45% coinsurance	Not Covered	
If you need help recovering or have other special	Home health care	45% coinsurance	Not Covered	Limited to 28 hours /week, not to exceed 60 visits/year.
	Rehabilitation services	$140 copay /visit, deductible does not apply	Not Covered	Limits/year: Physical, Occupational, Speech: 20 visits each; Cardiac, Pulmonary: Unlimited visits each

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)	
health needs				Visit limits do not apply for a primary diagnosis of Mental Health Care, Substance-Related and Addictive Disorders or Autism Spectrum Disorder.
	Habilitative services	PT/OT/ST for Autism: 45% coinsurance All Other Therapies: $140 copay /visit, deductible does not apply	Not Covered	Limits/year: Speech, Occupational, Physical: 20 visits each Visit limits do not apply for a primary diagnosis of Mental Health Care, Substance-Related and Addictive Disorders or Autism Spectrum Disorder.
	Skilled nursing care	45% coinsurance	Not Covered	Skilled nursing is limited to 100 days/year. Inpatient rehabilitation limited to 60 days/year.
	Durable medical equipment	45% coinsurance	Not Covered	None
	Hospice services	45% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge, deductible does not apply	Not Covered	Limited to 1 exam/12 months.
	Children's glasses	45% coinsurance	Not Covered	Limited to 1 pair/12 months.
	Children's dental check-up	No Charge, deductible does not apply	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.)		
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Routine foot care - except as covered for certain diseases
• Dental care (Adult)	• Routine eye care (Adult)	• Weight loss programs
• Long-term care		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion	• Chiropractic (manipulative) care - 20 visits/year	• Infertility treatment - diagnosis and treatment of underlying causes
• Acupuncture - 6 visits/year	• Hearing aids - 1 per hearing impaired ear /5 years	
• Bariatric surgery		• Private-duty nursing - inpatient only

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: Rocky Mountain Health Maintenance Organization, Inc. at 1-888-809-6539 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 Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202, 1-800-930-3745, DORA_Insurance@state.co.us or doi.colorado.gov 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 Colorado Division of Insurance at 1-800-930-3745, DORA_Insurance@state.co.us or doi.colorado.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 1-888-809-6539
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-809-6539
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-809-6539
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-809-6539

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	$7,500
Specialist copayment	$140
Hospital (facility) coinsurance	45%
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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$7,500
Copayments	$300
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,960**

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

The plan's overall deductible	$7,500
Specialist copayment	$140
Hospital (facility) coinsurance	45%
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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$700**

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

The plan's overall deductible	$7,500
Specialist copayment	$140
Hospital (facility) coinsurance	45%
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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,100
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,700**

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We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member ID card. (TTY 711).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Mail: Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

Email: UHC_Civil_Rights@uhc.com

If you need help with your complaint, please call the toll-free phone number listed on your ID card (TTY/RTT 711). We are available Monday through Friday, 8 a.m. to 8 p.m. E.T.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

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

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

This notice is available at:

https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices.

ATTENTION: If you speak **English**, free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card.
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ملاحظة: إذا كنت تتحدث اللغة **العربية (Arabic)**، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم المجاني المدون على بطاقة تعريف العضو خاصتك.
請注意：如果您說**中文(Chinese - Traditional)**，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。
توجه: اگر به زبان **فارسی (Persian-Farsi)** صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با شماره رایگان مندرج روی کارت شناسایی عضویت‌تان تماس بگیرید.
ATTENTION: Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.
ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum große Schrift, zur Verfügung. Rufen Sie die gebührenfreie Nummer auf Ihrer Mitgliedskarte an.
LUS TSEEM CEEB: Yog tias koj hais **lus Hmoob (Hmong)**, cov kev pab cuam lus pub dawb thiab kev sib txuas lus dawb hauv lwm hom ntawv, xws li luam ntawv loj, muaj rau koj. Thov hu rau tus xov tooj hu dawb ntawm koj daim npav ID.
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