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, visit www.umr.com or by calling 1-800-826-9781. 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.umr.com or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** person / **$2,000** family UCHealth and In-network **$2,000** person / **$4,000** family Out-of-network Does not apply to copayments and services listed below as "No Charge" unless noted otherwise in Limitations & Exceptions column.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. Preventive care services 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 https://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?	**$6,000** person / **$12,000** family UCHealth and In-network **$12,000** person / **$24,000** family Out-of-network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Penalties, 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 www.umr.com or call 1-800-826-9781 for a list of network providers as well as UCHealth (UCH) Providers.	You pay the least if you use a provider with UCHealth. You pay more if you use a non-UCHealth provider in the United Options PPO 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
		UCHealth (You will pay the least)	In-network (You will pay less than Out-of-network	Out-of-network (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	$25 copay per visit	$45 copay per visit	40% coinsurance	Deductible waived UCH and In-network
	Specialist visit	$50 copay per visit	$60 copay per visit	40% coinsurance	Deductible waived UCH and In-network
	Preventive care/screening/ immunization	No charge	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance x-ray; No charge blood work	20% coinsurance x-ray; No charge blood work	40% coinsurance	Deductible waived UCH and In-network blood work
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	40% coinsurance	Prior authorization is required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.magellanrx.com.	Generic drugs (Tier 1)	See In-network column	Retail $10 copay; Mail order $20 copay	Must pay 100% & submit Member Reimbursement form. 50% of network pharmacy cost after copay	Deductible waived Over-the-counter drugs are not covered Once the annual out-of-pocket limit is met, you pay nothing for covered prescription medication Specialty drugs must be ordered through the Magellan Rx specialty pharmacy
	Preferred brand drugs (Tier 2)	See In-network column	Retail 20% coinsurance, with a minimum copay of $25 and a maximum copay of $50; Mail Order 2x Retail		
	Non-preferred brand drugs (Tier 3)	See In-network column	Retail 50% coinsurance, with a minimum copay of $50 and a maximum copay of $100; Mail Order 2x Retail		

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UCHealth (You will pay the least)	In-network (You will pay less than Out-of-network	Out-of-network (You will pay the most)	
	Specialty drugs (Tier 4)	See In-network column	$100 copay /30 day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	$250 copay per visit; 30% coinsurance	$500 copay per visit; 40% coinsurance	Copay applies to first billed facility or physician; prior authorization is required
	Physician/surgeon fees	20% coinsurance	20% coinsurance	$500 copay per visit; 40% coinsurance	Deductible waived Out-of-network; copay applies to first billed physician or facility
If you need immediate medical attention	Emergency room care	$200 copay per ER visit; 20% coinsurance x-rays done during ER visit	$200 copay per ER visit; 20% coinsurance x-rays done during ER visit	$200 copay per ER visit; 20% coinsurance x-rays done during ER visit	Deductible waived ER visit; In-network deductible applies to Out-of-network benefits x-rays during ER visit; copay may be waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	In-network deductible applies to Out-of-network benefits
	Urgent care	$50 copay per Urgent care visit; 20% coinsurance x-rays	$50 copay per Urgent care visit; 20% coinsurance x-rays	$50 copay per Urgent care visit; 40% coinsurance x-rays	Deductible waived Urgent care visit
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$500 copay; 30% coinsurance	$500 copay per admission; 40% coinsurance	Deductible waived Out-of-network; prior authorization is required
	Physician/surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	——none——

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UCHealth (You will pay the least)	In-network (You will pay less than Out-of-network	Out-of-network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit; 20% coinsurance other outpatient services	$25 copay per visit; 20% coinsurance other outpatient services	40% coinsurance	Deductible waived In-network office visits; prior authorization is required
	Inpatient services	20% coinsurance	20% coinsurance	$500 copay per admission; 40% coinsurance	Deductible waived Out-of-network; prior authorization is required
If you are pregnant	Office visits	$25 copay initial visit, then 20% coinsurance	$45 copay for initial visit then 30%	40% coinsurance	Deductible waived Out-of-network; prior authorization is required
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	$500 copay; 30% coinsurance	$500 copay; 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	40% coinsurance	100 Maximum visits per calendar year; prior authorization is required
	Rehabilitation services	$25 copay per visit	$25 copay per visit	40% coinsurance	Deductible waived In-network
	Habilitation services	Not covered	Not covered	Not covered	———none———
	Skilled nursing care	20% coinsurance	20% coinsurance	$500 copay per occurrence; 40% coinsurance	100 Maximum days per calendar year; deductible waived Out-of-network; prior authorization is required
	Durable medical equipment	20% coinsurance	20% coinsurance	40% coinsurance	Prior authorization is required for DME in excess of $500 for rentals or $1,500 for purchases
	Hospice services	20% coinsurance	20% coinsurance	$500 copay per occurrence; 40% coinsurance Inpatient; 40% coinsurance Outpatient	Deductible waived Out-of-network Inpatient
If your child needs dental or eye care	Eye exam	$25 copay per visit	$25 copay per visit	$25 copay per visit	Deductible waived; $130 maximum benefit per

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UCHealth (You will pay the least)	In-network (You will pay less than Out-of-network	Out-of-network (You will pay the most)	
					calendar year; 1 Maximum exam per calendar year
	Glasses	Not covered	Not covered	Not covered	————none————
	Dental check-up	Not covered	Not covered	Not covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Routine foot care
- Infertility treatment
- Long-term care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Hearing aids (if due to a covered illness or injury)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan Provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standard? **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 1-800-826-9781.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-826-9781.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-826-9781.]

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 UCH in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$60
Coinsurance	$1,860
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,920**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$740
Coinsurance	$146
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,886**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$792
Copayments	$275
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,067**

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