



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](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:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | <u>Network</u> : \$8,000 Individual / \$16,000 Family                                                                                                                                                                                      | 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> .                                                                                                                                                               |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Benefits available with no charge such as <u>Network Preventive care</u> services are covered before you meet your <u>deductible</u> . The <u>cost-sharing</u> below indicates whether the <u>deductible</u> applies for each benefit | 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 <a href="https://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a> .                                                              |
| <b>Are there other deductibles for specific services?</b>          | No.                                                                                                                                                                                                                                        | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>What is the out-of-pocket limit for this plan?</b>              | <u>Network</u> : \$10,600 Individual / \$21,200 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.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="https://uhc.com/xcodocfindrmv2026">uhc.com/xcodocfindrmv2026</a> or call 1-888-809-6539 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 <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a referral to see a specialist?</b>                 | 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<br>(You will pay the least)                                                                                                                                                                                                                                            | Out-of-Network Provider<br>(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 | \$20 <u>copay</u> /visit, <u>deductible</u> does not apply                                                                                                                                                                                                                              | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                  | <u>Specialist</u> visit                          | \$110 <u>copay</u> /visit, <u>deductible</u> does not apply                                                                                                                                                                                                                             | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                  | <u>Preventive care/ screening/ immunization</u>  | No Charge, <u>deductible</u> does not apply                                                                                                                                                                                                                                             | 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:<br>Free Standing/Office: \$50 <u>copay</u> /service, <u>deductible</u> does not apply<br>Hospital: \$100 <u>copay</u> /service, <u>deductible</u> does not apply<br>X-Ray/Diagnostics:<br>Free Standing/Office: 35% <u>coinsurance</u><br>Hospital: 40% <u>coinsurance</u> | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                  | Imaging (CT/PET scans, MRIs)                     | Free Standing/Office: 35% <u>coinsurance</u><br>Hospital: 40% <u>coinsurance</u>                                                                                                                                                                                                        | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <u>prescription drug coverage</u> is available at <a href="http://uhc.com/xcodruglist2026">uhc.com/xcodruglist2026</a> | Tier 1 – Zero <u>Cost-Share</u> Preventive Drugs | No Charge, <u>deductible</u> does not apply                                                                                                                                                                                                                                             | 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 cost-share. Mail-Order: Up to a 90-day supply at 2.5x the 30-day cost-share. <u>Specialty drugs</u> 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 covered at No Charge, <u>deductible</u> does not apply. See the website listed for information on drugs covered |
|                                                                                                                                                                                                                  | Tier 2 – Preferred Generic                       | \$15 <u>copay</u> /prescription, <u>deductible</u> does not apply                                                                                                                                                                                                                       | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                  | Tier 3 – Preferred Brand                         | \$150 <u>copay</u> /prescription, <u>deductible</u> does not apply                                                                                                                                                                                                                      | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                  | Tier 4 – Non-Preferred Brand                     | \$300 <u>copay</u> /prescription, <u>deductible</u> does not apply                                                                                                                                                                                                                      | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                  | Tier 5 – Specialty                               | \$700 <u>copay</u> /prescription, <u>deductible</u> does not apply                                                                                                                                                                                                                      | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

| Common Medical Event                                                      | Services You May Need                          | What You Will Pay                                                                                                                                                                                                           |                                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                             |
|---------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                | Network Provider<br>(You will pay the least)                                                                                                                                                                                | Out-of-Network Provider<br>(You will pay the most)         |                                                                                                                                                                                                                                                    |
|                                                                           |                                                |                                                                                                                                                                                                                             |                                                            | by your <u>plan</u> . Not all drugs are covered. Insulin products listed as Tier 1 on the <u>Prescription Drug List</u> are covered at No Charge, <u>deductible</u> does not apply at a <u>network</u> pharmacy.                                   |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | 35% <u>coinsurance</u>                                                                                                                                                                                                      | Not Covered                                                | None                                                                                                                                                                                                                                               |
|                                                                           | Physician/surgeon fees                         | Free Standing/Office:<br>35% <u>coinsurance</u><br>Hospital: 40% <u>coinsurance</u>                                                                                                                                         | Not Covered                                                | None                                                                                                                                                                                                                                               |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     | 35% <u>coinsurance</u>                                                                                                                                                                                                      | 35% <u>coinsurance</u>                                     | None                                                                                                                                                                                                                                               |
|                                                                           | <u>Emergency medical transportation</u>        | 35% <u>coinsurance</u>                                                                                                                                                                                                      | 35% <u>coinsurance</u>                                     | None                                                                                                                                                                                                                                               |
|                                                                           | <u>Urgent care</u>                             | \$65 <u>copay</u> /visit, <u>deductible</u> does not apply                                                                                                                                                                  | \$65 <u>copay</u> /visit, <u>deductible</u> does not apply | Virtual visits - No Charge by a Designated Virtual <u>Network Provider</u> , <u>deductible</u> does not apply.                                                                                                                                     |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | 40% <u>coinsurance</u>                                                                                                                                                                                                      | Not Covered                                                | None                                                                                                                                                                                                                                               |
|                                                                           | Physician/surgeon fees                         | 40% <u>coinsurance</u>                                                                                                                                                                                                      | Not Covered                                                | None                                                                                                                                                                                                                                               |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | Office Visit: \$80 <u>copay</u> /visit, <u>deductible</u> does not apply<br>Intensive Outpatient: 35% <u>coinsurance</u><br>Partial Hospitalization: 35% <u>coinsurance</u><br>All Other Outpatient: 35% <u>coinsurance</u> | Not Covered                                                | None                                                                                                                                                                                                                                               |
|                                                                           | Inpatient services                             | 40% <u>coinsurance</u>                                                                                                                                                                                                      | Not Covered                                                | None                                                                                                                                                                                                                                               |
| If you are pregnant                                                       | Office visits                                  | No Charge, <u>deductible</u> does not apply                                                                                                                                                                                 | 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 services described elsewhere in |
|                                                                           | Childbirth/delivery professional services      | 40% <u>coinsurance</u>                                                                                                                                                                                                      | Not Covered                                                |                                                                                                                                                                                                                                                    |

| Common Medical Event                                                  | Services You May Need                 | What You Will Pay                                                                                                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                    |
|-----------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                       | Network Provider<br>(You will pay the least)                                                                                    | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                           |
|                                                                       | Childbirth/delivery facility services | 40% <u>coinsurance</u>                                                                                                          | Not Covered                                        | the SBC (i.e., ultrasound.)                                                                                                                                                                                                                               |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>               | 35% <u>coinsurance</u>                                                                                                          | Not Covered                                        | Limited to 28 hours /week, not to exceed 60 visits/year.                                                                                                                                                                                                  |
|                                                                       | <u>Rehabilitation services</u>        | \$110 <u>copay</u> /visit, <u>deductible</u> does not apply                                                                     | Not Covered                                        | Limits/year: Physical, Occupational, Speech: 20 visits each; Cardiac, Pulmonary: Unlimited visits each<br>Visit limits do not apply for a primary diagnosis of Mental Health Care, Substance-Related and Addictive Disorders or Autism Spectrum Disorder. |
|                                                                       | <u>Habilitative services</u>          | PT/OT/ST for Autism: 35% <u>coinsurance</u><br>All Other Therapies: \$110 <u>copay</u> /visit, <u>deductible</u> does not apply | Not Covered                                        | Limits/year: Physical, Speech, Occupational: 20 visits each<br>Visit limits do not apply for a primary diagnosis of Mental Health Care, Substance-Related and Addictive Disorders or Autism Spectrum Disorder.                                            |
|                                                                       | <u>Skilled nursing care</u>           | 40% <u>coinsurance</u>                                                                                                          | Not Covered                                        | Skilled nursing is limited to 100 days/year.<br>Inpatient rehabilitation limited to 60 days/year.                                                                                                                                                         |
|                                                                       | <u>Durable medical equipment</u>      | 35% <u>coinsurance</u>                                                                                                          | Not Covered                                        | None                                                                                                                                                                                                                                                      |
|                                                                       | <u>Hospice services</u>               | 35% <u>coinsurance</u>                                                                                                          | Not Covered                                        | None                                                                                                                                                                                                                                                      |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                   | No Charge, <u>deductible</u> does not apply                                                                                     | Not Covered                                        | Limited to 1 exam/12 months.                                                                                                                                                                                                                              |
|                                                                       | Children's glasses                    | 35% <u>coinsurance</u>                                                                                                          | Not Covered                                        | Limited to 1 pair/12 months.                                                                                                                                                                                                                              |
|                                                                       | Children's dental check-up            | No Charge, <u>deductible</u> 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 | • Private-duty nursing - inpatient only                                |
| • Bariatric surgery           |                                                      |                                                                        |

**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](https://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](https://doi.colorado.gov) 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 Colorado Division of Insurance at 1-800-930-3745, DORA\_Insurance@state.co.us or [doi.colorado.gov](https://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](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 1-888-809-6539

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): Dinekehgo shika at'ohwol ninisingo, kwijijgo 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 <u>plan's overall deductible</u>   | \$8,000 |
| ■ <u>Specialist copayment</u>            | \$110   |
| ■ Hospital (facility) <u>coinsurance</u> | 40%     |
| ■ Other <u>coinsurance</u>               | 35%     |

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> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <u>Deductibles</u>                     | <b>\$8,000</b>  |
| <u>Copayments</u>                      | <b>\$400</b>    |
| <u>Coinsurance</u>                     | <b>\$800</b>    |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | <b>\$60</b>     |
| <b>The total Peg would pay is</b>      | <b>\$9,260</b>  |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                          |         |
|------------------------------------------|---------|
| ■ The <u>plan's overall deductible</u>   | \$8,000 |
| ■ <u>Specialist copayment</u>            | \$110   |
| ■ Hospital (facility) <u>coinsurance</u> | 40%     |
| ■ Other <u>coinsurance</u>               | 35%     |

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> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <u>Deductibles</u>                     | <b>\$200</b>   |
| <u>Copayments</u>                      | <b>\$400</b>   |
| <u>Coinsurance</u>                     | <b>\$0</b>     |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | <b>\$0</b>     |
| <b>The total Joe would pay is</b>      | <b>\$600</b>   |

### Mia's Simple Fracture

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

|                                          |         |
|------------------------------------------|---------|
| ■ The <u>plan's overall deductible</u>   | \$8,000 |
| ■ <u>Specialist copayment</u>            | \$110   |
| ■ Hospital (facility) <u>coinsurance</u> | 40%     |
| ■ Other <u>coinsurance</u>               | 35%     |

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> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <u>Deductibles</u>                     | <b>\$2,100</b> |
| <u>Copayments</u>                      | <b>\$600</b>   |
| <u>Coinsurance</u>                     | <b>\$0</b>     |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | <b>\$0</b>     |
| <b>The total Mia would pay is</b>      | <b>\$2,700</b> |

## **Nondiscrimination Notice and Notice of Availability of Language Assistance Services and Alternate Formats**

The Rocky Mountain Health Plans (“We” or “we”) complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

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](mailto: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](tel:1-800-368-1019), [1-800-537-7697](tel: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

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>.

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| <b>ATTENTION:</b> If you speak <b>English</b> , 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.                                                   |
| <b>ማሳሰቢያ፡- አማርኛ (Amharic)</b> የሚናገሩ ከሆነ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባሮች እንደ ትልቅ አትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያ ቅጥርዎ ላይ የለውን ነፃ የሰልክ ቁጥር ይጻፉ።                                                                                                                               |
| <b>ملاحظة:</b> 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.                                                                     |
| <b>請注意：</b> 如果您說 <b>中文 (Chinese - Traditional)</b> ，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。                                                                                                                                                                                   |
| <b>توجه:</b> 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 عضویتان تماس بگیرید.                                                                |
| <b>ATTENTION:</b> Si vous parlez <b>français (French)</b> , 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. |
| <b>ACHTUNG:</b> Falls Sie <b>Deutsch (German)</b> sprechen, stehen Ihnen kostenlose Sprachassistentendienste und kostenlose Kommunikation in anderen Formaten, wie zum große Schrift, zur Verfügung. Rufen Sie die gebührenfreie Nummer auf Ihrer Mitgliedskarte an.                   |
| <b>LUS TSEEM CEEB:</b> Yog tias koj hais <b>lus Hmoob (Hmong)</b> , 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.                                       |
| <b>알림사항:</b> 한국어(Korean)를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.                                                                                                                                                          |

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| <p><b>ध्यान दिनुहोस्:</b> यदि तपाईंले <b>नेपाली (Nepali)</b> बोल्नुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू र अन्य ढाँचाहरूमा निःशुल्क संचारहरू, जस्तै ठूलो छाप, तपाईंका लागि उपलब्ध छन्। आफ्नो सदस्य पहिचान काडमा रहेको टोल फ्रोनम्बरमा कल गर्नुहोस्।</p>                                                      |
| <p><b>ВНИМАНИЕ:</b> Если вы говорите на <b>русском языке (Russian)</b>, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например, напечатанные крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.</p> |
| <p><b>ATENCIÓN:</b> Si habla <b>español (Spanish)</b>, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro.</p>                                           |
| <p><b>PAUNAWA:</b> Kung nagsasalita ka <b>ng Tagalog (Tagalog)</b>, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.</p>                                 |
| <p><b>โปรดทราบ</b> หากคุณพูดไทย (<b>Thai</b>) ได้ คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่น ๆ ฟรี เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่ โทรไปยังหมายเลขโทรฟรีสำหรับสมาชิกตามบัตรประจำตัวของคุณ</p>                                                                                           |
| <p><b>УВАГА:</b> Якщо ви розмовляєте <b>українською (Ukrainian)</b>, вам надаються безкоштовні мовні послуги та безкоштовні повідомлення в інших форматах, наприклад, крупним шрифтом.<br/>Зателефонуйте за безкоштовним номером телефону, позначеним на Вашій ідентифікаційній картці.</p>                    |
| <p><b>LƯU Ý:</b> Nếu quý vị nói Tiếng <b>Việt (Vietnamese)</b>, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ nhận dạng thành viên của quý vị.</p> |