



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.uhcsr.com/colburnschool or call 1-800-505-4160. For general definitions of common terms, such as allowed amount, balance billing, coinsurance (coins), copayment (copay), deductible (ded), provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-505-4160 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Preferred Providers</u> \$250 / (Person) <u>Out-of-Network Providers</u> \$600 / (Person)	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.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , Pediatric Dental Preventive and Diagnostic Services, Pediatric Vision and categories that specify <u>ded</u> does not apply.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. Pediatric Dental \$500. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	<u>Preferred Providers</u> \$7,500 / (Person) <u>Preferred Providers</u> \$13,700 / (Family) <u>Out-of-Network Providers</u> \$15,000 / (Person)	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<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> .
Will you pay less if you use a network provider?	Yes. See www.uhcsr.com/colburnschool or call 1-800-505-4160 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.
Do you need a referral to see a specialist?	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
		Preferred 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	\$25 <u>Copay</u> /per visit 20% <u>Coins ded</u> does not apply	50% <u>Coins</u>	Does not apply when related to surgery or Physiotherapy.
	<u>Specialist visit</u>	\$25 <u>Copay</u> /per visit 20% <u>Coins ded</u> does not apply	50% <u>Coins</u>	
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	Includes <u>preventive services</u> specified in the health care reform law or benefits provided as mandated by state law. 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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
	Imaging (CT/PET scans, MRIs)	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.uhcsr.com/capdl	Tier 1 - Your Lowest-Cost Option	\$25 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply	Not Covered	<u>Preferred Providers</u> : up to a 31 day supply per prescription <u>Preferred Providers</u> : Mail Order <u>Network Pharmacy</u> or Preferred 90 Day Retail <u>Network Pharmacy</u> at 2.5 times the retail <u>Copay</u> up to a 90-day supply. You may need to obtain certain <u>specialty drugs</u> from a pharmacy designated by us. You may need to obtain <u>prior authorization</u> for certain <u>prescription drugs</u> . You may pay more if <u>prior authorization</u> is not obtained.
	Tier 2 - Your Midrange-Cost Option	\$60 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply	Not Covered	
	Tier 3 - Your Highest-Cost Option	\$75 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply	Not Covered	
	Tier 4 - Additional High-Cost Option	Not Applicable	Not Applicable	
	Facility fee (e.g., ambulatory surgery center)	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Physician/surgeon fees	20% <u>Coins</u>	50% <u>Coins</u>	If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>Copay</u> per visit 20% <u>Coins</u> <u>ded</u> does not apply	\$150 <u>Copay</u> per visit 20% <u>Coins</u> <u>ded</u> does not apply	May be limited to use of emergency room and supplies. The Preferred Provider and Out-of-Network <u>Provider Copay</u> will be waived if admitted to the Hospital. Out-of-Network Provider: (The Insured's expense shall not exceed the amount payable for <u>Preferred Provider</u> Medical Emergency Expenses.)
	<u>Emergency medical transportation</u>	20% <u>Coins</u>	20% <u>Coins</u>	Out of Network Provider: (The Insured's ground or air ambulance expense shall not exceed the amount payable for <u>Preferred Provider</u> ground or air ambulance services.)
	<u>Urgent care</u>	\$50 <u>Copay</u> per visit 20% <u>Coins</u> <u>ded</u> does not apply	\$50 <u>Copay</u> per visit 50% <u>Coins</u> <u>ded</u> does not apply	May be limited to facility fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
	Physician/surgeon fees	20% <u>Coins</u>	50% <u>Coins</u>	If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.
If you need mental health, behavioral	Outpatient services	Office Visits: \$25 <u>Copay</u> per visit	Office Visits: 50% <u>Coins</u> Other: 50% <u>Coins</u>	—————none—————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
health, or substance abuse services		20% <u>Coins</u> <u>ded</u> does not apply Other: 20% <u>Coins</u>		
	Inpatient services	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
If you are pregnant	Office visits	Routine Office Visit: No charge Office visit related to complications: \$25 <u>Copay</u> per visit 20% <u>Coins</u> <u>ded</u> does not apply	50% <u>Coins</u>	Cost sharing does not apply for preventive services when provided by a Preferred Provider. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>Coins</u>	50% <u>Coins</u>	
	Childbirth/delivery facility services	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
	<u>Rehabilitation services</u>	20% <u>Coins</u>	50% <u>Coins</u>	Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. This review does not apply to Mental Illness Treatment or Substance Use Disorder Treatment.
	<u>Habilitation services</u>	20% <u>Coins</u>	50% <u>Coins</u>	Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. This review does not apply to Mental Illness Treatment or Substance Use Disorder Treatment.
	<u>Skilled nursing care</u>	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
	<u>Durable medical equipment</u>	20% <u>Coins</u>	20% <u>Coins</u>	—————none—————
	<u>Hospice services</u>	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
If your child needs dental or eye care	Children's eye exam	\$20 <u>Copay</u> per exam; <u>ded</u> does not apply	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*
	Children's glasses	Lens: \$40 <u>Copay</u> ; <u>ded</u> does not apply	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Frames: Tiered <u>Copays</u> from no charge to 40% based on retail cost. <u>ded</u> does not apply		
	Children's dental check-up	No Charge; <u>ded</u> does not apply	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Dental Benefit Details. Age limits apply.*

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
- Infertility treatment
- Routine foot care
- Dental care (Adult) except as noted in the policy
- Long-term care
- Weight loss programs
- Hearing aids
- Routine eye care (Adult)

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

- Acupuncture
- Non-emergency care when traveling outside the U.S.
- Bariatric surgery
- Private-duty nursing
- Chiropractic care

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: UnitedHealthcare Student Resources at 1-800-505-4160 and California Department of Insurance at 1-800-927-4357 or visit <http://www.insurance.ca.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: California Department of Insurance at 1-800-927-4357 or visit <http://www.insurance.ca.gov/>.

Additionally, a consumer assistance program can help you file your appeal, contact California Department of Insurance Consumer Communications Bureau at 300 South Spring Street, South Tower, Los Angeles, CA 90013 or call 1-800-927-4357 or 1-800-382-4TDD (4833) or visit <http://www.insurance.ca.gov/>.

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 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 1-866-260-2723.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-260-2723.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-260-2723.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-260-2723.

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's overall deductible</u>	\$250	■ The <u>plan's overall deductible</u>	\$250	■ The <u>plan's overall deductible</u>	\$250
■ <u>Specialist copayment</u>	\$25	■ <u>Specialist copayment</u>	\$25	■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%
This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)		This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost-Sharing</i>		<i>Cost-Sharing</i>		<i>Cost-Sharing</i>	
<u>Deductibles</u>	\$250	<u>Deductibles</u>	\$250	<u>Deductibles</u>	\$250
<u>Copayments</u>	\$25	<u>Copayments</u>	\$1,000	<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$2,500	<u>Coinsurance</u>	\$300	<u>Coinsurance</u>	\$400
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$2,835	The total Joe would pay is	\$1,570	The total Mia would pay is	\$1,050

UNITEDHEALTHCARE INSURANCE COMPANY

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE PROGRAM

NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources does not discriminate or treat Insureds differently on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

If you think you were treated unfairly for any of these reasons, you can send a complaint to:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

If you think you were treated unfairly because of your ancestry, religion, marital status, gender, gender identity, or sexual orientation, you can also send a complaint to the California Department of Insurance:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll-Free Consumer Hotline: 1-800-927-HELP (4357) or 1-213-897-8921
TDD Number: 1-800-482-4TDD (4833)
<http://www.insurance.ca.gov>

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can also file a complaint with the U.S. Dept. of Health and Human Services.

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

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

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

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

LANGUAGE ASSISTANCE PROGRAM

We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English

Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian

Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

Amharic

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Arabic

تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian

Ձեզ փախչելի են անվճար լեզվախոս օգնություն
ծառայություններ: Խնդրում ենք զանգահարել
1-866-260-2723 համարով:

Bantu- Kirundi

Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha.
Utegerezwa guhamagara 1-866-260-2723.

Bisayan- Visayan (Cebuano)

Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga
walay bayad. Palihug tawag sa 1-866-260-2723.

Bengali- Bangala

ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে
পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

Burmese

ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သဘောတရား အကြံပြု
အခမဲ့ရရှိနိုင်ပါသည်။ ဝက်စ်ဘ်ဆိုက် ၁၆၆၆ ၁-၈၆၆-၂၆၀-၂၇၂၃
ကို ခေါ်ဝေါ်ပါ။

Cambodian- Mon-Khmer

សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។
សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

Cherokee

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Chinese

您可以免費獲得語言援助服務。請致電 1-866-260-2723。

Choctaw

Chahta anumpa ish anumpuli hokmyt tohsholi yvt peh pillā hō
chi apela hinla. I paya 1-866-260-2723.

Cushite- Oromo

Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira.
Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

Dutch

Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve
1-866-260-2723 op te bellen.

French

Des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-866-260-2723.

French Creole- Haitian Creole

Gen sèvis èd pou lang ki disponib gratis pou ou. Rele
1-866-260-2723.

German

Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur
Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

Greek

Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν.
Καλέστε το 1-866-260-2723.

Gujarati

ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. કૃપા કરીને
1-866-260-2723 પર કોલ કરો.

Hawaiian

Kōkua manuahi ma kāu ‘ōlelo i loa‘a ‘ia. E kelepona i ka helu
1-866-260-2723.

Hindi

आप के लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपया
1-866-260-2723 पर कॉल करें।

Hmong

Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau
1-866-260-2723.

Ibo

Enyemaka na-ahazi asụsụ, bu n'efu, dịrị gị. Kpọọ
1-866-260-2723.

Ilocano

Adda awan bayadna a serbisio para iti language assistance.
Pangngaasim ta tawagam ti 1-866-260-2723.

Indonesian

Layanan bantuan bahasa bebas biaya tersedia untuk Anda.
Harap hubungi 1-866-260-2723.

Italian

Sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero 1-866-260-2723.

Japanese

無料の言語支援サービスをご利用いただけます。
1-866-260-2723 までお電話ください。

Karen

ကျိတ်တိမၤဆၢနီၤနီၤဆၢနီၤဆၢနီၤသ့ၤလၢတလိၣ်ဟ့ၣ်ဆၢနီၤဘၣ်(ခိလိ)န့ၣ်လီၤ.
ဝံသးစူးဆဲးကျိးဘၣ်1-866-260-2723တက့ၢ်.

Korean

언어 지원 서비스를 무료로 이용하실 수 있습니다.
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