




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, you can get the complete policy or plan document at tpa.uchealth.org or by calling 1-800-207-1018.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For network providers \$3,500 individual / \$7,000 family. For out-of-network providers \$7,000 individual / \$14,000 family.	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy 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 is covered 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.	The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is the out-of-pocket limit for this plan ?	Yes. For participating providers \$4,500 individual / \$9,000 family. For out-of-network providers \$9,000 individual / \$18,000 family.	The out-of-pocket limit is the most you could pay during a policy period 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 ?	Premium, balance-billed charges, preauthorization penalty, medical management ineligible expense penalty, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Will you pay less if you use a network provider ?	Yes. Members can locate providers either through the Colorado network, Cofinity, or through the Texas network, PHCS Healthy Directions. To locate a list of In-Network providers, access the provider directory search tool in the Member Portal located at: https://tpa.uchealth.org . Otherwise, members can locate Cofinity & First Health providers by visiting: https://providerlocator.firsthealth.com/LocateProvider/SelectNetworkType	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term in-network , preferred , or participating for providers in their network.
Do you need a referral to see a specialist ?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	Teladoc Visit Fee: \$0 copay For access to a doctor via phone, video or mobile app, call Teladoc: 800-835-2362 or visit www.Teladoc.com
	Specialist visit	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	
	Chiropractic visit	Deductible , then 0% coinsurance	Not applicable	20 visit annual maximum
	Preventive care/screening/immunization	No charge	Deductible , then 50% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	
	Imaging (CT/PET scans, MRIs)	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	Preauthorization required. Failure to comply may result in a penalty of \$1,000 per incident.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	Deductible , then 25% coinsurance	Not covered	Preauthorization may be required, penalties may apply.
	Preferred brand drugs	Deductible , then 25% coinsurance	Not covered	Preauthorization may be required, penalties may apply.
	Non-preferred brand drugs	Deductible , then 25% coinsurance	Not covered	Preauthorization may be required, penalties may apply.
	Specialty drugs	Deductible , then 25% coinsurance up to a maximum of \$250 per prescription	Not covered	Only available through Briova – 30 day supply. Preauthorization required, penalties may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	Preauthorization required. Failure to comply may result in a penalty of \$1,000 per incident.
	Physician/surgeon fees	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	Preauthorization required. Failure to comply may result in a penalty of \$1,000 per incident.
If you need immediate medical attention	Emergency room care	Deductible , then 0% coinsurance	Deductible , then 0% coinsurance	
	Emergency medical transportation	Deductible , then 0% coinsurance	Deductible , then 0% coinsurance	
	Urgent care	Deductible , then 0% coinsurance	Deductible , then 0% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	Preauthorization required. Failure to comply may result in a penalty of \$1,000 per incident.
	Physician/surgeon fees	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	Preauthorization required. Failure to comply may result in a penalty of \$1,000 per incident.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	
	Inpatient services	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	Preauthorization required. Failure to comply may result in a penalty of \$1,000 per incident.
If you are pregnant	Office visits	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	
	Childbirth/delivery professional services	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	Preauthorization required. Failure to comply may result in a penalty of \$1,000 per incident.
	Childbirth/delivery facility services	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	Preauthorization required. Failure to comply may result in a penalty of \$1,000 per incident.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	Preauthorization required. Failure to comply may result in a penalty of \$1,000 per incident. Plan maximum of 60 visits per illness/injury.
	Rehabilitation services	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	Preauthorization required. Failure to comply may result in a penalty of \$1,000 per incident. 60 visits combined annual maximum for Physical, Speech & Occupational Therapy.
	Habilitation services	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	Preauthorization required. Failure to comply may result in a penalty of \$1,000 per incident. 60 day calendar year maximum.
	Skilled nursing care	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	Preauthorization required for equipment over \$500. Failure to comply may result in a penalty of \$1,000 per incident.
	Durable medical equipment	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	Preauthorization required. Failure to comply may result in a penalty of \$1,000 per incident.
	Hospice services	Deductible , then 0% coinsurance	Deductible , then 50% coinsurance	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine hearing exams (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: UCHealth Plan Administrators at 1-800-207-1018.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-207-1018.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist \[cost sharing\]](#) 0%
- Hospital (facility) [\[cost sharing\]](#) 0%
- Other [\[cost sharing\]](#) 0%

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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$3,500

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist \[cost sharing\]](#) 0%
- Hospital (facility) [\[cost sharing\]](#) 0%
- Other [\[cost sharing\]](#) 0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$3,800

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist \[cost sharing\]](#) 0%
- Hospital (facility) [\[cost sharing\]](#) 0%
- Other [\[cost sharing\]](#) 0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800