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 **$2,000** individual / **$6,000** family. For out-of-network providers **$4,000** individual / **$12,000** 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	$30 **copay**/visit – any additional services /charges subject to **deductible**, then 20% **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	$50 **copay**/visit – any additional services /charges subject to **deductible**, then 20% **coinsurance**	**Deductible**, then 50% **coinsurance**	
	Chiropractic visit	$40 **copay**/visit - any additional services/charges subject to **deductible**, then 20% **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)	Lab: **Deductible**, then 20% **coinsurance** Radiology: **Deductible**, then 20% coinsurance	**Deductible**, then 50% **coinsurance**	BEST Measures incentive available for lab and radiology services at certain, low-cost sites. Contact UCHealth Plan Administrators before getting services.
	Imaging (CT/PET scans, MRIs)	**Deductible**, then 20% **coinsurance**	**Deductible**, then 50% **coinsurance**	Preauthorization required. Failure to comply may result in a penalty of $1,000 per incident. BEST Measures incentives available for radiology services at certain, low-cost sites. Contact UCHealth Plan Administrators before getting services.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.MyOptumRx.com	Generic drugs	$20 **copay**/prescription (retail - 30 day supply) $40 **copay**/prescription (mail order - 90 day supply)	Not covered	Preauthorization may be required, penalties may apply.
	Preferred brand drugs	$35 **copay**/prescription (retail - 30 day supply) $70 **copay**/prescription (mail order - 90 day supply)	Not covered	Preauthorization may be required, penalties may apply.
	Non-preferred brand drugs	$55 **copay**/prescription (retail - 30 day supply) $110 **copay**/prescription (mail order - 90 day supply)	Not covered	Preauthorization may be required, penalties may apply.
	Specialty drugs	25% **coinsurance** up to a maximum of $250 per prescription	Not covered	Only available through Briova – 30 day supply. Preauthorization **required**, penalties may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Deductible**, then 20% **coinsurance**	**Deductible**, then 50% **coinsurance**	Preauthorization required. Failure to comply may result in a penalty of $1,000 per incident. BEST Measures incentives available for procedures at certain, low-cost sites. Contact UCHealth Plan Administrators before getting services.
	Physician/surgeon fees	**Deductible**, then 20% **coinsurance**	**Deductible**, then 50% **coinsurance**	Preauthorization required. Failure to comply may result in a penalty of $1,000 per incident. BEST Measures incentives available for procedures at certain, low-cost sites. Contact UCHealth Plan Administrators before getting services.
If you need immediate	Emergency room care	$100 **copay**, then	$100 **copay**, then	

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)	
medical attention		services/charges exceeding $1,000 subject to **deductible**, then 20% **coinsurance**	services/charges exceeding $1,000 subject to **deductible**, then 20% **coinsurance**	
	Emergency medical transportation	**Deductible**, then 20% **coinsurance**	**Deductible**, then 20% **coinsurance**	
	Urgent care	$50 **copay** - any additional services/charges subject to **deductible**, then 20% **coinsurance**	$50 **copay** - any additional services/charges subject to **deductible**, then 20% **coinsurance**	
If you have a hospital stay	Facility fee (e.g., hospital room)	**Deductible**, then 20% **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 20% **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	$35 **copay**/visit	**Deductible**, then 50% **coinsurance**	
	Inpatient services	**Deductible**, then 50% **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	Primary care: $30 **copay**/visit. Specialty care: $50 **copay**/visit	**Deductible**, then 50% **coinsurance**	Teladoc Visit Fee: $0 For access to a doctor via phone, video or mobile app, call Teladoc: 800-835-2362 or visit www.Teladoc.com
	Childbirth/delivery professional services	**Deductible**, then 20% **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 20% **coinsurance**	**Deductible**, then 50% **coinsurance**	Preauthorization required. Failure to comply may result in a penalty of $1,000 per incident.
If you need help	Home health care	**Deductible**, then 20%	**Deductible**, then 50%	Preauthorization required. Failure to comply

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)	
recovering or have other special health needs		**coinsurance**	**coinsurance**	may result in a penalty of $1,000 per incident. Plan maximum of 60 visits per illness/injury
	Rehabilitation services	$40 **copay**/visit	**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	$40 **copay**/visit	**Deductible**, then 50% **coinsurance**	
	Skilled nursing care	**Deductible**, then 20% **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.
	Durable medical equipment	**Deductible**, then 20% **coinsurance**	**Deductible**, then 50% **coinsurance**	Preauthorization required for equipment over $500. Failure to comply may result in a penalty of $1,000 per incident.
	Hospice services	**Deductible**, then 20% **coinsurance**	**Deductible**, then 50% **coinsurance**	Preauthorization required. Failure to comply may result in a penalty of $1,000 per incident.
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.

About these Coverage Examples:

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

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	**$2,000**
Specialist *[cost sharing]*	**$50**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$360
Coinsurance	$2,140
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,500**

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

The plan's overall deductible	**$2,000**
Specialist *[cost sharing]*	**$50**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$75
Copayments	$830
Coinsurance	$520
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,425**

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

The plan's overall deductible	**$2,000**
Specialist *[cost sharing]*	**$50**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,700
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**