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 970-490-3382 or 970-490-3499 or visit www.psdschools.org. 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 https://www.healthcare.gov/sbc-glossary or call 970-490-3382 or 970-490-3499 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** individual / **$3,000** family for network providers	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and outpatient mental health and substance use services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
What is the out-of-pocket limit for this plan?	For network providers **$7,600** individual / **$15,200** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Charges for hearing aids (for participants age 19 and up), acupuncture, and prescriptions; premiums, balance-billing charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See http://tpa.uchealth.org or call 1-866-644-7873 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services

		(such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-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% coinsurance	Not covered	None
	Specialist visit	30% coinsurance	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Retail: 10% coinsurance ($10 minimum); Mail order: $25 copay per prescription	Not covered	Covers up to a 34-day supply (retail); 90-day supply (mail order); out-of-pocket limit $1,500 individual / $3,000 family – does not apply toward medical out-of-pocket limit
	Preferred brand drugs	Retail: 20% coinsurance ($20 minimum); Mail order: $75 copay per prescription	Not covered	Covers up to a 34-day supply (retail); 90-day supply (mail order); out-of-pocket limit $1,500 individual / $3,000 family – does not apply toward medical out-of-pocket limit
	Non-preferred brand drugs	Retail: 30% coinsurance ($40 minimum); Mail order: $125 copay per prescription	Not covered	Covers up to a 34-day supply (retail); 90-day supply (mail order); out-of-pocket limit $1,500 individual / $3,000 family – does not apply toward medical out-of-pocket limit
	Specialty drugs	30% coinsurance ($40 minimum)	Not covered	Covers up to a 34-day supply; out-of-pocket limit $1,500 individual / $3,000 family – does not apply toward medical out-of-pocket limit
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefit payment by the plan will be reduced by $500 and amounts paid by you will not apply toward the deductible or out-

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				of-pocket limit.
	Physician/surgeon fees	30% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefit payment by the plan will be reduced by $500 and amounts paid by you will not apply toward the deductible or out-of-pocket limit.
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance if immediate care is required	Non-network providers: Not covered if immediate care is not required
	Emergency medical transportation	30% coinsurance	30% coinsurance if immediate care is required	Non-network providers: Not covered if immediate care is not required
	Urgent care	30% coinsurance	30% coinsurance if immediate care is required	Non-network providers: Not covered if immediate care is not required
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefit payment by the plan will be reduced by $500 and amounts paid by you will not apply toward the deductible or out-of-pocket limit. Exceptions apply for Bariatric procedures.
	Physician/surgeon fees	30% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefit payment by the plan will be reduced by $500 and amounts paid by you will not apply toward the deductible or out-of-pocket limit. Exceptions apply for Bariatric procedures.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No deductible; 30% coinsurance	Not Covered	Preauthorization is required through Employee Assistance Services for certain services. If you don't get preauthorization, benefit payment by the plan will be reduced to 50% of usual and customary and amounts paid by you will not apply toward the out-of-pocket limit. Out-of-pocket limits are combined with medical.
	Inpatient services	30% coinsurance	Not covered	Preauthorization is required through Employee Assistance Services for certain services. If you don't get preauthorization, amounts paid by you will not apply toward the deductible or out-of-pocket limit. Out-of-pocket limits are combined with medical.
If you are pregnant	Office visits	30% coinsurance	Not covered	None
	Childbirth/delivery professional services	30% coinsurance	Not covered	None
	Childbirth/delivery facility services	30% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, there will be no benefit payment by the plan and amounts paid by you will not apply toward the deductible or out-of-pocket limit.
	Rehabilitation services	30% coinsurance	Not covered	60-day plan year limit on length of stay for in-patient care. 30 visits/acute condition includes physical, occupational, and speech therapy limited. Must obtain referral from primary care physician. If referral not in place, there will be no benefit payment by the plan.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	30% coinsurance	Not covered	60-day plan year limit on length of stay. Preauthorization is required. If you don't get preauthorization, there will be no benefit payment by the plan and amounts paid by you will not apply toward the deductible or out-of-pocket limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Durable medical equipment	30% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, there will be no benefit payment by the plan and amounts paid by you will not apply toward the deductible or out-of-pocket limit.
	Hospice services	No charge	Not covered	180-day maximum. Preauthorization is required. If you don't get preauthorization, there will be no benefit payment by the plan and amounts paid by you will not apply toward the deductible or out-of-pocket limit.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Available under voluntary vision plan.
	Children's glasses	Not covered	Not covered	Available under voluntary vision plan.
	Children's dental check-up	Not covered	Not covered	Available under dental plan.

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
- Dental care (adult/dependents)
- Eye exams
- Glasses
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult/dependents)
- Weight loss programs

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

- Acupuncture (Preauthorization is required.)
- Bariatric surgery (Preauthorization is required.)
- Chiropractic care (Preauthorization is required.)
- Gender affirmation (Preauthorization is required.)
- Hearing aids (Preauthorization is required.)
- Infertility treatment (Preauthorization is required.)
- Routine foot 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.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 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 1-866-644-7873 or Poudre School District Benefits Services at 970-490-3382 or 970-490-3499.

Does this plan provide Minimum Essential Coverage? **Yes**

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

Does this plan meet the Minimum Value 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:

Para obtener asistencia en Español, llame al 970-490-3680.

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	$1,000
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$3,540
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,600**

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

The plan's overall deductible	$1,000
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$1,920
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,980**

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

The plan's overall deductible	$1,000
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$270
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,270**

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