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, refer to www.medschool.ucdenver.edu/gme/healthdental, www.MyAmeriBen.com or 1-866-955-1498. 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.MyAmeriBen.com or call 1-866-955-1498 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	**Network** **Per participant:** $0 **Per family:** $0	**Non-Network** **Per participant:** $750 **Per family:** $1,200	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?	No.		You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.		No. You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Medical Network** **Per participant:** $800 **Per family:** $1200	**Medical Non-Network** **Per participant:** Unlimited **Per family:** Unlimited	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.
	Prescription Network **Per participant:** $800 **Per family:** $1200	**Prescription Non-Network** **Per participant:** Unlimited **Per family:** Unlimited	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, charges over the allowed amount, and cost containment penalties.		Even though you pay these expenses, they don't count toward the out-of-pocket limit.

For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.com **or** www.medschool.ucdenver.edu/gme/healthdental.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	**Yes, for medical:** CU GME Health Benefits Plan Proprietary Network. For a list of network providers, call AmeriBen Customer Care, at 1-866-955-1498 or visit www.medschool.ucdenver.edu/gme/healthdental. **Yes, for behavioral health:** Mines and Associates and CU Medicine Behavioral/Mental Health Providers. For listings of network providers and additional contact information, call AmeriBen Customer Care, at 1-866-955-1498 or visit www.medschool.ucdenver.edu/gme/healthdental. **Yes, for prescription drugs:** Navitus. For a list of retail and mail pharmacies, log on to www.navitus.com.	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 a non-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 a non-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	$20 co-payment per visit	50% after deductible	——————————none——————————
	Specialist visit	$20 co-payment per visit	50% after deductible	——————————none——————————
	Preventive care/screening/ immunization	No charge	Ages 0-2: 50% after deductible Ages 2 and older: 50% after deductible up to limit (see comment)	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. Immunizations related to travel are not covered. Non-network charges may be paid at 100% of the allowed amount for a laboratory test or tissue specimen obtained in the office of a network provider. Plan year limits for services provided by non-

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)	
				network providers: Ages 2-18 Physical exam and laboratory: $150 Ages 19 and over: $500 Immunizations: $60
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% after deductible	**Pre-certification is required** for genetic testing. Failure to pre-certify will result in denial of benefits. Non-network charges may be paid at 100% of the allowed amount for a laboratory test or tissue specimen obtained in the office of a network provider.
	Imaging (CT/PET scans, MRIs)	$100 co-payment per outpatient scan	50% after deductible	**Pre-certification is required** for these outpatient services. Failure to pre-certify will result in denial of benefits.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com	Tier 1 Typically Formulary Generic Drugs	**Retail Pharmacy** $10 co-payment per 30-day supply **Mail Order** $20 co-payment per 90-day supply	**Retail Pharmacy (30-day supply)** The amount reimbursable to the plan participant from the Prescription Drug Plan will be the amount allowable by the Prescription Drug Plan less the $10 co-payment	Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.navitus.com. If a brand name drug is selected when a generic is available, the plan participant will pay the brand name co-payment plus difference between generic and brand charges. With a written prescription and as required under the ACA, some over-the-counter products such as certain tobacco use cessation medications and certain preventive medications are covered at no charge from a network pharmacy. Certain generic and single source brand name prescription contraceptives, tobacco use cessation medications, and generic breast cancer prevention medications are covered at no charge from a network pharmacy as required under the ACA.
	Tier 2 Typically Formulary Preferred Brand Drugs	**Retail Pharmacy** $25 co-payment per 30-day supply **Mail Order** $50 co-payment per 90-day supply	**Retail Pharmacy (30-day supply)** The amount reimbursable to the plan participant from the Prescription Drug Plan will be the amount allowable by the Prescription Drug Plan less the $25 co-payment	
	Tier 3 Typically Formulary Non-Preferred Brand Drugs	**Retail Pharmacy** $50 co-payment per 30-day supply **Mail Order** $100 co-payment per 90-day supply	**Retail Pharmacy (30-day supply)** The amount reimbursable to the plan participant from the Prescription Drug Plan will be the amount allowable by the Prescription Drug Plan less the $50 co-payment	
	Tier 4 Specialty drugs	**Specialty Pharmacy** $75 co-payment per 30-day supply	Not Available	Some drugs require pre-authorization. To determine if a specific drug is covered under your plan, log into your account at www.navitus.com. Specialty drugs are limited to a 30-day supply. All applicable co-payments and plan provisions apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 co-payment per day	50% after deductible	Network co-payment waived if admitted from outpatient department. If surgery is performed in conjunction with emergency room care, only

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)	
				emergency room co-payment applies. **Pre-certification is required.** Failure to pre-certify will result in denial of claims.
	Physician/surgeon fees	No charge	50% after deductible or No charge (see Comment)	Non-network fees may be paid as network if pre-certified and when a plan participant has no control over provider selection.
If you need immediate medical attention	Emergency room care	$200 co-payment per visit	$200 co-payment per visit	Waived if admitted directly from emergency room.
	Emergency medical transportation	No Charge	50% after deductible for a non-medical emergency; no charge for a medical emergency or if pre-certified	——————————none——————————
	Urgent care	$20 co-payment per visit	50% after deductible or $20 co-payment per visit (See Comment)	Network office visit co-payment will apply for: network physician visit, network urgent care/ER alternative facility. Non-Network facility charges and related physician charges incurred at time of presentation to an urgent care facility may be paid as network if plan participant is traveling greater than fifty (50) miles from residence (for purposes other than to seek non-preapproved medical care) and/or resident participating in away rotation.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 co-payment per confinement	50% after deductible or $200 co-payment per confinement if an emergency admission and all other plan provisions are met.	Co-payment is per confinement. For continuous confinements only one (1) co-payment will apply. Limited to semi-private room rate. Non-network emergency admissions, when certified within the specified time period, pay at the higher benefit until patient can be transferred to a network facility, based on bed availability, as soon as his/her condition safely permits, or benefits revert to 50% after deductible. **Pre-certification is required.** Failure to pre-certify will result in denial of claims.

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)	
	Physician/surgeon fees	No Charge	50% after deductible or No Charge (see Comments).	Non-network fees may be paid as network if pre-certified and a plan participant has no control over provider selection.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 co-payment per visit	50% after deductible	——————————none——————————
	Inpatient services	$200 co-payment per admission	50% after deductible	Non-network charges may be paid at 100% if an emergency admission and is pre-certified within a specified time period. Plan participant must be transferred to a network facility as soon as his/her condition safely permits, or benefits revert to 50%. **Pre-certification is required.** Failure to pre-certify will result in denial of claims.
If you are pregnant	Office visits	$20 co-payment per office visit	50% after deductible	Co-payments are for office visits that are not included in Global Physician's Charge. Dependent child pregnancy is not covered.
	Childbirth/delivery professional services	$200 co-payment for Global Physician's Charge	50% after deductible	**Pre-certification is required** for stays over 48-hours (vaginal delivery) or 96-hours (cesarean delivery). Failure to pre-certify will result in denial of claims. Dependent child pregnancy is not covered.
	Childbirth/delivery facility services	$200 co-payment per admission	50% after deductible	
If you need help recovering or have other special health needs	Home health care	No charge	50% after deductible	**Pre-certification is required.** Failure to pre-certify will result in denial of claims.
	Rehabilitation services	No charge	50% after deductible	**Pre-certification is required** for outpatient occupational therapy and speech therapy/auditory rehabilitation services. Failure to pre-certify will result in denial of claims. Combined 20 visit limit per plan year. Physical Therapy does not require pre-certification. 40 visit limit per plan year.
	Habilitation services	No charge	50% after deductible	Only in cases of Pervasive Developmental Disorder in pre-kindergarten children. **Pre-certification is required** for outpatient occupational therapy and speech therapy/auditory rehabilitation services.

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)	
				Failure to pre-certify will result in denial of claims. Combined 20 visit limit per plan year.
	Skilled nursing care	$200 co-payment per admission	50% after deductible	Limited to semi-private room rate and a plan year maximum of 100 days. **Pre-certification is required.** Failure to pre-certify will result in denial of claims.
	Durable medical equipment	No charge	50% after deductible	**Pre-certification is required** for items costing more than $500 and/or rented more than 60 days. Failure to pre-certify will result in denial of claims.
	Hospice services	No charge	50% after deductible	**Pre-certification is required.** Failure to pre-certify will result in denial of claims.
If your child needs dental or eye care	Children's eye exam	No coverage	No coverage	Dental and vision coverage are separate elections.
	Children's glasses	No coverage	No coverage	
	Children's dental check-up	No coverage	No coverage	

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
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing – except as described in the Plan
- Routine eye care (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.)

- Hearing aids (with limitations)

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: AmeriBen, P.O. Box 7186, Boise ID 83707, 1-866-955-1498. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services 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 the Plan Administrator at 1-303-724-6024 or AmeriBen at 1-866-955-1498, P.O. Box 7186, Boise, ID 83707.

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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-955-1498.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-955-1498.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-955-1498.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-955-1498.

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	$0
Specialist co-payment	$200
Hospital (facility) co-payment	$200
Other co-insurance	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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$410**

This coverage example assumes the baby is enrolled in the Plan.

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

The plan's overall deductible	$0
Specialist co-payment	$20
Hospital (facility) co-payment	$200
Other co-insurance	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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,200**

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

The plan's overall deductible	$0
Specialist co-payment	$20
Hospital (facility) co-payment	$200
Other co-insurance	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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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