
 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 970-490-3499 or visit [www.psdschools.org](http://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 970-490-3499 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$1,500</b> individual / <b>\$4,500</b> family for <a href="#">network providers</a>	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and outpatient mental health and substance use services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> <b>\$7,700</b> individual / <b>\$15,400</b> family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Charges for hearing aids (for participants age 19 and up), acupuncture, and prescriptions; <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://simplifiedbenefitsadministrators.org">https://simplifiedbenefitsadministrators.org</a> or call 1-800-207-1018 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	30% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Specialist</a> visit	30% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	Not covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic drugs	Retail: 10% <a href="#">coinsurance</a> (\$10 minimum); Mail order: \$30 <a href="#">copay</a> per prescription	Not covered	Covers up to a 34-day supply (retail); 90-day supply (mail order); <a href="#">out-of-pocket limit</a> \$1,500 individual / \$3,000 family – does not apply toward medical <a href="#">out-of-pocket limit</a>
	Preferred brand drugs	Retail: 20% <a href="#">coinsurance</a> (\$20 minimum); Mail order: \$150 <a href="#">copay</a> per prescription	Not covered	Covers up to a 34-day supply (retail); 90-day supply (mail order); <a href="#">out-of-pocket limit</a> \$1,500 individual / \$3,000 family – does not apply toward medical <a href="#">out-of-pocket limit</a>
	Non-preferred brand drugs	Retail: 30% <a href="#">coinsurance</a> (\$40 minimum); Mail order: \$250 <a href="#">copay</a> per prescription	Not covered	Covers up to a 34-day supply (retail); 90-day supply (mail order); <a href="#">out-of-pocket limit</a> \$1,500 individual / \$3,000 family – does not apply toward medical <a href="#">out-of-pocket limit</a>
	<a href="#">Specialty drugs</a>	30% <a href="#">coinsurance</a> (\$40 minimum)	Not covered	Covers up to a 34-day supply; <a href="#">out-of-pocket limit</a> \$1,500 individual / \$3,000 family – does not apply toward medical <a href="#">out-of-pocket limit</a>
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefit payment by the <a href="#">plan</a> will be reduced by \$500 and amounts paid by you will not apply toward the <a href="#">deductible</a> or <a href="#">out-of-pocket limit</a> .

\* For more information about limitations and exceptions, see the plan or policy document at [www.psdschools.org](http://www.psdschools.org).

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	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefit payment by the <u>plan</u> will be reduced by \$500 and amounts paid by you will not apply toward the <u>deductible</u> or <u>out-of-pocket limit</u> .
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <u>coinsurance</u>	30% <u>coinsurance</u> if immediate care is required	<u>Non-network providers</u> : Not covered if immediate care is not required
	<a href="#">Emergency medical transportation</a>	30% <u>coinsurance</u>	30% <u>coinsurance</u> if immediate care is required	<u>Non-network providers</u> : Not covered if immediate care is not required
	<a href="#">Urgent care</a>	30% <u>coinsurance</u>	30% <u>coinsurance</u> if immediate care is required	<u>Non-network providers</u> : Not covered if immediate care is not required
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefit payment by the <u>plan</u> will be reduced by \$500 and amounts paid by you will not apply toward the <u>deductible</u> or <u>out-of-pocket limit</u> . Exceptions apply for Bariatric procedures.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefit payment by the <u>plan</u> will be reduced by \$500 and amounts paid by you will not apply toward the <u>deductible</u> or <u>out-of-pocket limit</u> . Exceptions apply for Bariatric procedures.

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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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No deductible; 30% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required through Employee Assistance Services for certain services. If you don't get <u>preauthorization</u> , benefit payment by the <u>plan</u> will be reduced to 50% of <u>usual and customary</u> and amounts paid by you will not apply toward the <u>out-of-pocket limit</u> . <u>Out-of-pocket limits are combined with medical</u> .
	Inpatient services	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required through Employee Assistance Services for certain services. If you don't get <u>preauthorization</u> , amounts paid by you will not apply toward the <u>deductible</u> or <u>out-of-pocket limit</u> . <u>Out-of-pocket limits are combined with medical</u> .
<b>If you are pregnant</b>	Office visits	30% <u>coinsurance</u>	Not covered	None
	Childbirth/delivery professional services	30% <u>coinsurance</u>	Not covered	None
	Childbirth/delivery facility services	30% <u>coinsurance</u>	Not covered	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , there will be no benefit payment by the <u>plan</u> and amounts paid by you will not apply toward the <u>deductible</u> or <u>out-of-pocket limit</u> .
	<a href="#">Rehabilitation services</a>	30% <u>coinsurance</u>	Not covered	60-day plan year limit on length of stay for inpatient care. 30 visits/acute condition includes physical, occupational, and speech therapy limited. Must obtain <u>referral</u> from primary care physician. If <u>referral</u> not in place, there will be no benefit payment by the <u>plan</u> .
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	30% <u>coinsurance</u>	Not covered	60-day plan year limit on length of stay. <u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , there will be no benefit payment by the <u>plan</u> and amounts paid by you will not apply toward the <u>deductible</u> or <u>out-of-pocket limit</u> .

\* For more information about limitations and exceptions, see the plan or policy document at [www.psdschools.org](http://www.psdschools.org).

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)	
	<a href="#">Durable medical equipment</a>	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , there will be no benefit payment by the <u>plan</u> and amounts paid by you will not apply toward the <u>deductible</u> or <u>out-of-pocket limit</u> .
	<a href="#">Hospice services</a>	No charge	Not covered	180-day maximum. <u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , there will be no benefit payment by the <u>plan</u> and amounts paid by you will not apply toward the <u>deductible</u> or <u>out-of-pocket limit</u> .
<b>If your child needs dental or eye care</b>	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	• Habilitation services	• Private-duty nursing
• Dental care (adult/dependents)	• Long-term care	• Routine eye care (adult/dependents)
• Eye exams	• Non-emergency care when traveling outside the U.S.	• Weight loss programs
• Glasses		

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

• Acupuncture ( <u>Preauthorization</u> is required.)	• Gender affirmation ( <u>Preauthorization</u> is required.)	• Infertility treatment ( <u>Preauthorization</u> is required.)
• Bariatric surgery ( <u>Preauthorization</u> is required.)	• Hearing aids ( <u>Preauthorization</u> is required.)	• Routine foot care
• Chiropractic care ( <u>Preauthorization</u> is required.)		

**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](http://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](http://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: Simplified Benefits Administrators at 1-800-207-1018 or Poudre School District Benefits Services at 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.

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

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

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

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

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

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$270
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,270</b>