



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, <https://www.anthem.com/cuhealthplan>. 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.healthcare.gov/sbc-glossary/ or call (800) 735-6072 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$500 /single or \$1,000 /family for In-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. Prescription Drugs and Preventive care for In-Network Providers .	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.	
What is the out-of-pocket limit for this plan ?	\$10,600 /single or \$21,200 /family for In-Network Providers .	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 ?	Pre-Authorization Penalties, Premiums , Balance-Billing charges, and Health Care this plan doesn't 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, Pathway providers. See www.anthem.com/cuhealthplan or call (800) 735-6072 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 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
		In-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/visit, deductible does not apply	Not covered	\$10 Copayment/visit for allergy injections. Other cost shares may apply depending on services provided. Virtual visits (Telehealth) benefits available.
	Specialist visit	\$40/visit, deductible does not apply	Not covered	Other cost shares may apply depending on services provided. Virtual visits (Telehealth) benefits available.
	Preventive care / screening /immunization	\$0 /visit, deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$20/lab visit, deductible does not apply \$20/x-ray procedure, deductible does not apply	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$20/procedure, deductible does not apply	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
If you need drugs to treat your illness or condition More information about prescription	Tier 1 - Typically Generic	• Caremark Retail Network Pharmacy Locations: \$10/prescription for up to a 30-day supply • CVS Retail, Cosco, Kroger or CVS Mail order: \$20/prescription for a 31 to 90-day supply	Not covered	Specialty RX: Per fill, a maximum of up to 30 days of Specialty medication may be purchased at a retail pharmacy. After 3 fills, CVS Specialty Pharmacy must be used for Specialty medication to be covered. Maintenance medication: Per fill, a

drug coverage under CVS's Standard Control Formulary with Advanced Control Specialty Formulary is available at https://info.caremark.com/dig/acsdruelist	Tier 2 - Typically Preferred Brand	• Caremark Retail Network Pharmacy Locations: \$50/prescription for up to a 30-day supply CVS Retail, Costco, Kroger or CVS Mail order: \$100/prescription for a 31 to 90-day supply	Not covered	maximum of up to 30 days of maintenance medication may be purchased at a retail pharmacy. After 3 fills, CVS Retail Pharmacies or CVS Mail Order Pharmacy must be used for maintenance medications, for up to a 90-day supply to be covered. GLP-1 medications for weight loss: \$100 copay per max 30-day fill. Diabetic Medication & Supplies: Members diagnosed with diabetes may be eligible to have insulin, generic
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* For more information about limitations and exceptions, see [plan](#) or policy document at <https://www.anthem.com/cuhealthplan>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Tier 3 - Typically Non-Preferred Brand	• Caremark Retail Network Pharmacy Locations: \$75/prescription for up to a 30-day supply • CVS Retail, Costco, Kroger, or CVS Mail order: \$150/prescription for a 31 to 90-day supply	Not covered	diabetic medications, pumps & supplies (needles, syringes, lancets, test strips) obtained at in network pharmacies with no applicable copayment (100% covered). Please contact member services for additional information. CVS Caremark Customer Care: 1-888-964-0121
	Tier4 - Typically Specialty Drugs	• Caremark Retail Network Pharmacy Locations: \$100/prescription for up to a 30-day supply • CVS Retail, Cosco, Kroger or CVS Mail order: \$75/prescription for up to a 30-day supply	Not covered	Prescription Drugs will always be dispensed as ordered by your Provider and by applicable State Pharmacy Regulations, however you may have higher out-of-pocket costs. You may request, or your Provider may order, the Brand Name Drug. However, if a Generic Drug is available, you will need to pay the cost difference between the Generic and Brand Name Drug, in addition to your tier Copayment. The cost difference between the Generic and Brand Name Drug does not contribute to the Out-of-Pocket Annual Maximum. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. The Plan reserves the right, at its discretion, to remove certain higher cost Generic Drugs from this coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
	Physician/surgeon fees	10% Coinsurance after deductible	Not covered	-----none-----

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://www.anthem.com/cuhealthplan>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$250 /visit, deductible does not apply	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	10% Coinsurance after deductible	Covered as In-Network	-----none-----
	Urgent care	\$30 /visit, deductible does not apply	Covered as In-Network	\$250 Copayment for urgent care received in an emergency room. \$15 Copayment for urgent care received through the UCHealth virtual visit platform.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
	Physician/surgeon fees	10% Coinsurance after deductible	Not covered	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit \$30/visit, deductible does not apply	Not covered	In-network: copayment applies to office visits and professional services. Failure to obtain pre-authorization may result in reduced or no coverage.
	Inpatient services	10% Coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
If you are pregnant	Office visits	\$15 Copayment for first prenatal care office visit, deductible does not apply	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) For inpatient admission, failure to obtain pre-authorization may result in reduced or no coverage.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	10% Coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	\$0 after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
	Rehabilitation services	Outpatient: \$30 /visit, deductible does not apply	Not covered	Outpatient coverage of physical, occupational and speech therapies is limited to 40 visits each per plan year. \$40 Copayment/visit for cardiac rehabilitation up to a maximum of 36 visits per plan year. All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Habilitation services	Outpatient: \$30 /visit, deductible does not apply	Not covered	

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://www.anthem.com/cuhealthplan>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Skilled nursing care	\$0 after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage. Covers up to 100 days per plan year.
	Durable medical equipment	20% Coinsurance not subject to deductible for Prosthetic Appliances; \$0 after deductible for all other durable medical equipment (100% covered)	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage. Includes 1 wig following cancer treatment.
	Hospice services	\$0 after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
If your child needs dental or eye care	Eye exam	\$20/visit, exam only, deductible does not apply	Not covered	-----none-----
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	-----none-----

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 .)		
- Private-duty nursing - Weight loss programs	- Cosmetic surgery - Long-term care - Routine foot care unless you have been diagnosed with diabetes	- Dental check-up Preauthorization - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. To find out which services require Preauthorization and to be sure that Preauthorization has been given, you may contact us.

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

- | | | |
|---|---------------------------------|--|
| • Acupuncture (20 visit maximum) | • Bariatric surgery | • Chiropractic care (20 visit maximum) |
| • Most coverage provided outside the United States www.bcbsglobalcore.com | • Hearing aids (1 pair/5 years) | • Infertility treatment |
| | | • Abortion |
| | | • Routine Eye Exam |

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://www.anthem.com/cuhealthplan>.

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 Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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:

ATTN: Grievances and Appeals, 700 Broadway, Mail Stop CO0104-0430, Denver, CO 80273

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490

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](#).

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	\$500
■ Specialist copayment	\$15
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	\$12,840
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$500
Copayments	\$15
Coinsurance	\$1,233
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$1748

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

■ The plan's overall deductible	\$500
■ PCP copayment	\$30
■ Lab copayment	\$20
■ Other coinsurance	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	\$7,460
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$500
Copayments	\$50
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$550

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$250
■ Other coinsurance	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	\$2,010
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$430
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$430

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (800) 735-6072

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 735-6072 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (800) 735-6072.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (800) 735-6072:

Bassa (Bàsɔ̀ wùdù): M̃ dyi dyi-diè-djé bɛ́ bédé b́á céè-djé nià ke dyí ní, ɔ̀ m̀ò nì dyí-bédjè̀n-djé b́é m̃ ké gbo-kpá-kpá kè b̃́ kp̃́ djé m̃ b́ídjí-wùdù̀ù̀n b́ó pídyi. B́é m̃ ké wuɖu-zìin-nyò djò gbo wùdù̀ ke, d́á (800) 735-6072.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (800) 735-6072 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (800) 735-6072 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(800) 735-6072。

Dinka (Dinka): Na n̄ɔŋ thiëc nē ke de yā thorē, ke yin n̄ɔŋ loŋ bē yi kuony ku w̄er alēu bē ḡɛɛr yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te k̄or yin ba jam wēnē ran ye thok geryic, ke yin c̄ol (800) 735-6072.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (800) 735-6072.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (800) 735-6072 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 735-6072.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (800) 735-6072.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (800) 735-6072.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ દૃઢો હોય તો, કોઈપણ ખર્ચવગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (800) 735-6072.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (800) 735-6072.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (800) 735-6072 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (800) 735-6072.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajuju ọ bụla gbasara akwụkwọ a, ị nwere ikike inweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (800) 735-6072.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (800) 735-6072.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (800) 735-6072.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 735-6072

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(800) 735-6072 にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (800) 735-6072 ។

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