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 801-213-4008 or visit https://uhealthplan.utah.edu/aruplabs/. 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 801-213-4008 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	**For In-Network Providers:** $750/Individual, $1,500/Family	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, Preventive care and prescription drugs. Deductible waived for the first $1,000 of accidental injury.	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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**For In-Network Providers:** $4,000/Individual, $8,000/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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, 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 https://uhealthplan.utah.edu/aruplabs/ or call 801-213-4008 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
		In-Network (You will pay the least)	Out-of-Network (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	15% coinsurance	Not covered	None.
	Specialist visit	15% coinsurance	Not covered	None
	Preventive care/screening/immunization	No Charge	Not covered	Frequency limitations apply. Deductible does not apply. 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)	15% coinsurance	Not covered	Preauthorization may be required for certain services or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com	Tier 1	**Retail: 1-30 Day:** $5 copay/Per Medication, Deductible does not apply. **31-60 Day:** $10 copay/Per Medication, Deductible does not apply. **61-90 Day:** $15 copay/Per Medication, Deductible does not apply. **Mail Order: 1-30 Day:** $5 copay/Per Medication, Deductible does not apply. **31-60 Day:** $10 copay/Per Medication, Deductible does not apply. **61-90 Day:** $12.50 copay/Per Medication, Deductible does not apply.	**Retail:** Not covered **Mail Order:** Not covered	Eligible covered charges apply to out-of-pocket limit. Certain compounded and preferred brand drugs are not covered under this plan. Contact the PBM for a list of excluded drugs. If a member or provider chooses a brand name drug when a generic is available, the member will be responsible for the appropriate copay plus the difference in cost between brand and generic. The difference in cost will not apply towards the plans out-of-pocket limit. However, if a provider recommends a particular contraceptive service or FDA-approved contraceptive item based on medical necessity for an
	Tier 2	**Retail: 1-30 Day:** $30 copay/Per Medication, Deductible does not apply.	**Retail:** Not covered **Mail Order:** Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
		31-60 Day: $60 copay/Per Medication, Deductible does not apply. **61-90 Day:** $90 copay/Per Medication, Deductible does not apply. **Mail Order: 1-30 Day:** $30 copay/Per Medication, Deductible does not apply. **31-60 Day:** $60 copay/Per Medication, Deductible does not apply. **61-90 Day:** $75 copay/Per Medication, Deductible does not apply.		individual, the Plan will cover the item at 100%. Enrollment in Specialty Access Program for certain specialty drugs is mandatory and requires prior authorization through Navitus.
	Tier 3	**Retail: 1-30 Day:** 35% coinsurance ($145 max), Deductible does not apply. **31-60 Day:** 35% coinsurance ($290 max), Deductible does not apply. **61-90 Day:** 35% coinsurance ($435 max), Deductible does not apply. **Mail Order: 1-30 Day:** 35% coinsurance ($145 max), Deductible does not apply. **31-60 Day:** 35% coinsurance ($290 max), Deductible does not apply. **61-90 Day:** 35% coinsurance ($375 max), Deductible does not apply.	**Retail:** Not covered **Mail Order:** Not covered	
	Specialty drugs	**1-30 Day:** 35% coinsurance ($145 max), Deductible does not apply. **Mail Order:** Not covered	**Retail:** Not covered **Mail Order:** Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	Not covered	Benefits may be denied for failure to obtain preauthorization for certain services.
	Physician/surgeon fees	15% coinsurance	Not covered	
	Emergency room care	$250 copay/Per Visit then 15% coinsurance	$250 copay/Per Visit then 15% coinsurance	**Copayment** is waived if admitted directly to a hospital or facility on an

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention				inpatient basis. Emergency room services apply to network provider benefits. Deductible waived for the first $1,000 of accidental injury.
	Emergency medical transportation	**Ambulance - Ground:** 15% coinsurance **Ambulance - Air:** 15% coinsurance	**Ambulance - Ground:** 15% coinsurance **Ambulance - Air:** 15% coinsurance	Non-emergency use is not covered. Deductible waived for the first $1,000 of accidental injury.
	Urgent care	15% coinsurance	**Within Coverage Area:** Not covered **Outside Coverage Area:** 15% coinsurance	Must see a contracted urgent care provider within the coverage area. Urgent care providers outside of Salt Lake, Davis, Weber, and Utah Counties will be covered at the In Network benefit level.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	Not covered	Preauthorization may be required for certain services or benefits may be denied.
	Physician/surgeon fees	15% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office:** 15% coinsurance **Other:** 15% coinsurance	**Office:** Not covered **Other:** Not covered	Preauthorization may be required for certain services or benefits may be denied. Additional limitations and exclusions apply.
	Inpatient services	15% coinsurance	Not covered	
If you are pregnant	Office visits	15% coinsurance	Not covered	Prenatal care includes routine lab services, breastfeeding support/supplies/counseling, screening for gestational diabetes, and immunizations, as required under health care reform. Preauthorization may be required for certain services or benefits may be denied.
	Childbirth/delivery professional services	15% coinsurance	Not covered	
	Childbirth/delivery facility services	15% coinsurance	Not covered	
If you need help recovering or have	Home health care	15% coinsurance	Not covered	Unlimited - Based on Medical Necessity. Prior authorization is required, or services are not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
other special health needs	Rehabilitation services	15% coinsurance	Not covered	Unlimited - Based on Medical Necessity for rehabilitation and habilitation services. Benefits may be denied for failure to obtain preauthorization for certain services. Neurodevelopmental therapy is limited to 40 outpatient visits per year for dependent children through age 6 only.
	Habilitation services	15% coinsurance	Not covered	
	Skilled nursing care	15% coinsurance	Not covered	SNF, Long Term Acute Care and Acute Rehab Unlimited - Based on Medical Necessity. Preauthorization may be required for certain services.
	Durable medical equipment	15% coinsurance	Not covered	Prior authorization is required for durable medical equipment over $5,000, or services are not covered.
	Hospice services	15% coinsurance	Not covered	Respite care limited to 14 days/incident. Prior authorization is required or benefits may be denied.
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Limited to one routine eye exam per plan year. Includes retinal/diabetes, detailed examination, and refraction.
	Children's glasses	Not covered	Not covered	Not Applicable.
	Children's dental check-up	Not covered	Not covered	Not Applicable.

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.)

- Abortions
- Cosmetic surgery
- Dental care
- Exercise programs
- Hearing aids
- Infertility treatment, except for diagnosis
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Vision Care
- Weight loss programs

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

- Acupuncture
- Autism ABA Therapy
- Bariatric surgery
- Chiropractic care
- Diabetes supplies
- Elective immunizations
- Genetic testing
- Imaging services
- Phototherapy
- Routine eye care; 1 visit per calendar year

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: University of Utah Health Plans at 801-213-4008, your state insurance department, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html. 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: Customer Service at 801-213-4008. You may also contact the Utah Insurance Department, Office of Consumer Assistance, Suite 3110 State Office Building, Salt Lake City UT 84114. For additional information about your grievance and appeals rights, see your Member Materials..

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance, available through the Marketplace or other indivdiual 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 Servicesss:

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 801-213-4008 TTY: 1-800-346-4128.

Chinese : 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請致電 801-213-4008 TTY: 1-800-346-4128.

* For more information about limitations and exceptions, see the plan or policy document at https://uhealthplan.utah.edu/aruplabs/

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụhỗtrợngôn ngữmiễn phí dành cho bạn. Gọi số801-213-4008 TTY: 1-800-346-4128.

Korean: 주의! 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 801-213-4008 TTY: 1-800-346-4128 번으로 전화해 주십시오.

Navajo: Dii baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 801-213-4008 TTY: 1- 800-346-4128.

Nepali: Nēpālī: Dhyāna: Yadi tapā'ī spēniśa bōlnuhuncha bhanē, tapā'īnsamga ni: Śulka bhā ā sahayōga sēvāharū chan. Kala garnuhōs 801-213-4008 TTY: 1-800-346-4128.

Tongan: FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai1 801-213-4008 TTY: 1-800-346-4128.

Serbo-Croation: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 801-213-4008 TTY: 1-800-346- 4128.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 801-213-4008 TTY: 1-800-346-4128.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 801-213-4008 TTY: 1- 800-346-4128.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 801-213-4008 (телетайп: 1-800-346-4128).

Arabic: alearabiat: tanbih: 'iidha kunt tatahadath al'iisbaniat , faladik khadamat musaeadat lighawyat majaniat. 'atasil bialraqm 801-213-4008 TTY: 1-800-346-4128.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 801-213-4008 (ATS: 1-800-346- 4128).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。801-213-4008 (TTY: 1-800-346-4128) まで、お電話にてご連絡ください。

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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	**$750**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

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	$750
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$2,610**

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

The plan's overall deductible	**$750**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

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	$750
Copayments	$100
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,170**

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

The plan's overall deductible	**$750**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

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	$750
Copayments	$255
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,205**

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