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, contact 1-888-271-5870. 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.uhealthplans.utah.edu or call 1-888-271-5870 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Network: $2,600 Individual / $5,200 Family. Multiplan Network: $5,000 Individual / $10,000 Family. Out of Network: $10,000 Individual / $20,000 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 plan, the family deductible must be met 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 is 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?	Yes	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: $6,350 Individual / $12,700 Family. Out of Network: $20,000 Individual / $40,000 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 family out-of-pocket must be met until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, 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, See www.uhealthlplans.utah.edu or call 1-888-271-5870 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 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
		Grand Valley Preferred Provider	MultiPlan Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copay AD	40% AD	50% AD	None
	Specialist visit	$75 Copay AD	40% AD	50% AD	None
	Preventive care/screening/ immunization	No Charge	No Charge	50% AD	Refer to plan document for a complete list of services
If you have a test	Diagnostic test (x-ray, blood work)	20% AD	40% AD	50% AD	None
	Imaging (CT/PET scans, MRIs)	20% AD	40% AD	50% AD	Preauth may be required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.simplesaverx.com	Prescriptions Administered by SimpleSave Questions call: 844-728-3479 www.simplesaverx.com				
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% AD	40% AD	50% AD	Preauth may be required
	Physician/surgeon fees	20% AD	40% AD	50% AD	
If you need immediate medical attention	Emergency room care	20% AD	40% AD	40% AD	
	Emergency medical transportation	20% AD	40% AD	40% AD	Non-emergency use not covered
	Urgent care	$75 Copay AD	40% AD	50% AD	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% AD	40% AD	50% AD	Preauth may be required.
	Physician/surgeon fees	20% AD	40% AD	50% AD	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay AD	40% AD	50% AD	None
	Inpatient services	20% AD	40% AD	50% AD	None
If you are pregnant	Office visits	$25 Copay AD	40% AD	50% AD	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Grand Valley Preferred Provider	MultiPlan Provider	Out-of-Network Provider	
	Childbirth/delivery professional services	20% AD	40% AD	50% AD	
	Childbirth/delivery facility services	20% AD	40% AD	50% AD	
If you need help recovering or have other special health needs	Home health care	20% AD	40% AD	50% AD	60 visits/year, preauth required
	Rehabilitation services	20% AD	40% AD	50% AD	40 visits/year, preauth required
	Habilitation services	20% AD	40% AD	50% AD	
	Skilled nursing care	20% AD	40% AD	50% AD	60 visits/year, preauth required
	Durable medical equipment	20% AD	40% AD	50% AD	Preauth required over $750
	Hospice services	20% AD	40% AD	50% AD	Preauth required
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	NA
	Children's glasses	Not Covered	Not Covered	Not Covered	NA
	Children's dental check-up	Not Covered	Not Covered	Not Covered	NA

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
- Private Duty Nursing
- Cosmetic Surgery
- Long-Term Care
- Non-emergent care when traveling outside the US
- Dental Care
- Hearing Aids
- Weight Loss Programs

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

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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. 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: University of Utah Health Plans, Attention Appeals Coordinator, PO Box 45180, Salt Lake City, UT 84145, or contact customer service at 1-888-271-5870

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.

* For more information about limitations and exceptions, see the plan or policy document at www.uhealthplan.utah.edu or call 1-888-271-5870

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 1-888-271-5870

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	$2600
Specialist *[cost sharing]*	$75
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	$2,600
Copayments	$50
Coinsurance	$2,487
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,197**

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

The plan's overall deductible	$2600
Specialist *[cost sharing]*	$75
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	$2,600
Copayments	$350
Coinsurance	$1,224
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$4,229**

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

The plan's overall deductible	$2600
Specialist *[cost sharing]*	$75
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	**$3,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,376
Copayments	$225
Coinsurance	$326
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,927**

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