
 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](http://www.uhealthplans.utah.edu) or call 1-888-271-5870 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	Preferred Network: \$4,500 Individual / \$9,000 Family. Multiplan Network: \$6,550 Individual / \$13,100 Family. Out of Network: \$10,000 Individual / \$20,000 Family	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> , the family deductible must be met until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> is 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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	In-Network: \$6,550 Individual / \$13,100 Family. Out of Network: \$20,000 Individual / \$40,000 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> , the family out-of-pocket must be met until the overall family out-of-pocket limit has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes, See <a href="http://www.uhealthplans.utah.edu">www.uhealthplans.utah.edu</a> or call 1-888-271-5870 for a list of network providers.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">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 provider's 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No	You can see the <a href="#">specialist</a> 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	0% AD	0% AD	50% AD	None
	<a href="#">Specialist</a> visit	0% AD	0% AD	50% AD	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	No Charge	50% AD	Refer to plan document for a complete list of services
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% AD	0% AD	50% AD	None
	Imaging (CT/PET scans, MRIs)	0% AD	0% AD	50% AD	Preauth may be required
<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.simplesaverx.com">www.simplesaverx.com</a>	Prescriptions Administered by SimpleSave  Questions call: 844-728-3479  <a href="http://www.simplesaverx.com">www.simplesaverx.com</a>				
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% AD	0% AD	50% AD	Preauth may be required
	Physician/surgeon fees	0% AD	0% AD	50% AD	
If you need immediate medical attention	<a href="#">Emergency room care</a>	0% AD	0% AD	0% AD	Copay waived if admitted directly to hospital or facility.
	<a href="#">Emergency medical transportation</a>	0% AD	0% AD	0% AD	Non-emergency use not covered
	<a href="#">Urgent care</a>	0% AD	0% AD	50% AD	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% AD	0% AD	50% AD	Preauth may be required.
	Physician/surgeon fees	0% AD	0% AD	50% AD	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% AD	0% AD	50% AD	None
	Inpatient services	0% AD	0% AD	50% AD	None
If you are pregnant	Office visits	0% AD	0% AD	50% AD	None

\* For more information about limitations and exceptions, see the plan or policy document at [www.uhealthplan.utah.edu](http://www.uhealthplan.utah.edu) or call 1-888-271-5870

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	0% AD	0% AD	50% AD	None
	Childbirth/delivery facility services	0% AD	0% AD	50% AD	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	0% AD	0% AD	50% AD	60 visits/year, preauth required
	<a href="#">Rehabilitation services</a>	0% AD	0% AD	50% AD	40 visits/year, preauth required
	<a href="#">Habilitation services</a>	0% AD	0% AD	50% AD	
	<a href="#">Skilled nursing care</a>	0% AD	0% AD	50% AD	60 visits/year, preauth required
	<a href="#">Durable medical equipment</a>	0% AD	0% AD	50% AD	Preauth required over \$750
	<a href="#">Hospice services</a>	0% AD	0% AD	50% AD	Preauth required
<b>If your child needs dental or eye care</b>	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](#).)**

<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Private Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery</li> <li>Long-Term Care</li> <li>Non-emergent care when traveling outside the US</li> </ul>	<ul style="list-style-type: none"> <li>Dental Care</li> <li>Hearing Aids</li> <li>Weight Loss Programs</li> </ul>
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**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](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: 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.

**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

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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>	\$4500
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	0%
■ Hospital (facility) [ <i>cost sharing</i> ]	0%
■ Other [ <i>cost sharing</i> ]	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*)

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

<i>Cost Sharing</i>	
Deductibles	\$4,500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,560</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>	\$4500
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	0%
■ Hospital (facility) [ <i>cost sharing</i> ]	0%
■ Other [ <i>cost sharing</i> ]	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*)

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

<i>Cost Sharing</i>	
Deductibles	\$4,500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$4,555</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>	\$4500
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	0%
■ Hospital (facility) [ <i>cost sharing</i> ]	0%
■ Other [ <i>cost sharing</i> ]	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*)

<b>Total Example Cost</b>	<b>\$3,500</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,925
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,925</b>