



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, uhealthplan.utah.edu. 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 1-888-271-5870 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	Network Providers: \$1,500/individual or \$3,000/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes, preventive care, office visits	This <u>plan</u> covers certain <u>preventive services</u> without cost sharing and before you meet your <u>deductible</u> . This <u>plan</u> covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	Yes, \$500/individual or \$1,000/family for <u>prescription drug</u>	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Network Providers: \$7,000/individual or \$14,000/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count towards the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes, See http://uhealthplan.utah.edu/individual/providers.php or call 1-888-271-5870	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	Out-of-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	\$25 Copayment deductible waived	Not Covered	None
	<u>Specialist</u> visit	\$40 Copayment deductible waived	Not Covered	None
	<u>Preventive care/screening/immunization</u>	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 needed are preventive. Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	15% Coinsurance	Not Covered	Benefits may be denied for failure to obtain preauthorization for certain services.
	Imaging (CT/PET scans, MRIs)	15% Coinsurance	Not Covered	Benefits may be denied for failure to obtain preauthorization for certain services.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://uhealthplan.utah.edu/individual/pharmacy.php	Tier 1 (Preferred Generic Drugs)	\$15 Copayment deductible waived	Not Covered	Certain limitations apply. Benefits may be denied for failure to obtain preauthorization for certain services. Refer to drug formulary for detailed information.
	Tier 2 (Non-Preferred Generic Drugs and Preferred Brand Drugs)	25% Coinsurance	Not Covered	
	Tier 3 (Non-Preferred Brand Drugs)	50% Coinsurance	Not Covered	
	Tier 4 (<u>Specialty drugs</u>)	25% Coinsurance	Not Covered	Benefits may be denied for failure to obtain preauthorization for certain services and must be filled at the University of Utah Pharmacy. Refer to drug formulary for detailed information.
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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	15% Coinsurance	Not Covered	Benefits may be denied for failure to obtain preauthorization for certain services.
If you need immediate medical attention	Emergency room care	\$200 Copayment	\$200 Copayment	Emergency room services apply to network provider benefits.
	Emergency medical transportation	\$250 Copayment	\$250 Copayment	Emergency medical transportation applies to network provider benefits.
	Urgent care	\$65 Copayment deductible waived	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% Coinsurance	Not Covered	Benefits may be denied for failure to obtain preauthorization for certain services.
	Physician/surgeon fees	15% Coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$25 Copayment deductible waived Other: 15% Coinsurance	Not Covered	Benefits may be denied for failure to obtain preauthorization for certain services. Additional limitations and exclusions apply.
	Inpatient services	15% Coinsurance	Not Covered	
If you are pregnant	Office visits	See PCP/SCP	Not Covered	Notify U Baby care team for care management services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	15% Coinsurance	Not Covered	
	Childbirth/delivery facility services	15% Coinsurance	Not Covered	
If you need help recovering or have other	Home health care	15% Coinsurance	Not Covered	Limited to 30 visits per year. 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
special health needs	Rehabilitation services	15% Coinsurance	Not Covered	Limited to 20 visits per year total for each rehabilitation and habilitation services. Benefits may be denied for failure to obtain preauthorization for certain services.
	Habilitation services	15% Coinsurance	Not Covered	
	Skilled nursing care	15% Coinsurance	Not Covered	Limited to 30 days per year. SNF and LTAC have a combined 30 day limit per year. Benefits may be denied for failure to obtain preauthorization for certain services.
	Durable medical equipment	15% Coinsurance	Not Covered	Prior authorization is required for durable medical equipment over \$750, or services are not covered.
	Hospice services	15% Coinsurance	Not Covered	Limited to six months in a three year period. Prior authorization is required, or services are not covered.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	One visit per plan year for children through age 18.
	Children's glasses	No Charge	No Charge	One set of corrective lenses per year. Frames are not covered.
	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/termination of pregnancy except in limited circumstances
- Acupuncture
- Autism spectrum disorder services greater than 600 hours
- Bariatric surgery
- Chiropractic Care
- Cosmetic surgery
- Dental Care
- Experimental and/or investigational services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Services that are not medically necessary
- Temporomandibular Joint (TMJ) services
- Weight loss programs

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

- Adoption services
- Mastectomy and breast reconstruction

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 1-888-271-5870. 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

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: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-271-5870 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1-888-271-5870 TTY: 1-800-346-4128。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-271-5870 TTY: 1-800-346-4128.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-1-888-271-5870 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 jiiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-888-271-5870 TTY: 1- 800-346-4128.

Nepali: ध्यान दिनुहोस: तपाइंले नेपाली बोल्नुहुन्छ भने तपाइंको ननतत भाषा सहायता सेवार्हू ननिशुल्क रूपमा उपलब्ध छ । फोन गनुहोस् 1-888-271-5870 (दिदिवाई: 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 mai 1-888-271-5870 TTY: 1-800-346-4128.

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-271-5870 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 1-888-271-5870 TTY: 1-800-346-4128.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-271-5870 TTY: 1-800-346-4128.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-271-5870 (телетайп: 1-800-346-4128).

Arabic: تادمذن، غللا ركذا تدتنتك اذا: عطوخله
مؤر) 1-888-271-5870مؤرب لصنا. ناجملاب لكل رناوتت قوغللا فدعاسملا
(800-346-4128اتف الصم واليكم: 1-

Mon-Khmer, Cambodian: រយ័ក្ុន៖ បរើសនជាអុន កនិយាយ ភាសាខ្មែរ, បសវាជំនួយខុនន កកាសា រោយមិន គគុលុន ល្អ
គីអាចមាសសំរារំបរអុន ក។ ចូរ ទរស្តីព្រ័ 1-888-271-5870 (TTY: 1-800-346-4128)។

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-271-5870 (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。1-888-271-5870（TTY: 1-800-346-4128）まで、お電話にてご連絡ください。

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	\$1,500
■ Specialist	\$40
■ Hospital (facility)	15%
■ Other	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	\$12,731
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$150
Coinsurance	\$1860
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,570

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,500
■ Specialist	\$40
■ Hospital (facility)	15%
■ Other	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	\$7,389
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$1,055
Coinsurance	\$1,175
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$4,285

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,500
■ Specialist	\$40
■ Hospital (facility)	15%
■ Other	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	\$2,442
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$538
Copayments	\$870
Coinsurance	\$48
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,456