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 1-833-981-0214 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>Network Providers: $1,500/individual or $3,000/family</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes, preventive care, office visits</td>
<td>This plan covers certain preventive services without cost sharing and before you meet your deductible. This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. As an example one adult annual routine eye exam is covered as preventive.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes, $500/individual or $1,000/family for prescription drug</td>
<td>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.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Network Providers: $7,000/individual or $14,000/family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count towards the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes, See <a href="http://uhealthplan.utah.edu/individual/providers.php">http://uhealthplan.utah.edu/individual/providers.php</a> or call 1-833-981-0214</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

Healthy Premier Gold Copay SBC 1/1/2020
**Common Medical Event**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least): $25 Copayment deductible waived</td>
<td>Out-of-Network Provider (You will pay the most): Not Covered</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$40 Copayment deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>More information about prescription drug coverage is available at <a href="http://uhealthplan.utah.edu/individual/pharmacy.php">http://uhealthplan.utah.edu/individual/pharmacy.php</a></td>
<td></td>
</tr>
<tr>
<td>Tier 1 (Preferred Generic Drugs)</td>
<td>$15 Copayment deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 2 (Non-Preferred Generic Drugs and Preferred Brand Drugs)</td>
<td>25% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 3 (Non-Preferred Brand Drugs)</td>
<td>50% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 4 (Specialty drugs)</td>
<td>25% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% Coinsurance</td>
</tr>
</tbody>
</table>

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>$200 Copayment</td>
<td>$200 Copayment</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$250 Copayment</td>
<td>$250 Copayment</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 Copayment deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: $25 Copayment deductible waived Other: 20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$25 Copayment deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need help recovering or have other</td>
<td>Home health care</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>special health needs</td>
<td>Rehabilitation services</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at www.uhealthplan.utah.edu.
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
- 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 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: University of Utah Health Plans at 1-833-981-0214, 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 1-833-981-0214. 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:

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 1-833-981-0214 TTY: 1-800-346-4128。


Navajo: Dii baa ak0 n7n7zin: D77 saad bee y1n7[tii ’go Diné Bizaad, saad bee 1k1′1n7da’1wo’d66’, t’11 jiik’eh, 47 n1 h0l=, koi8’ h0d77lnih 1-833-981-0214 TTY: 1- 800-346-4128.


Mon-Khmer, Cambodian: សម្រាប់ អន្តរជាតិដ៏ស្រស់ ស្រាប់ ប្រាក់ ការជាក់លាន, ដើរតែ ការជួយស្វែងរកឈ្មោះ ប្រាក់ ការជាក់លាន និង ការសម្រាប់ ការ នឹង សម្រាប់ 1-833-981-0214 (TTY: 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。1-833-981-0214（TTY: 1-800-346-4128）まで、お電話にてご連絡ください。

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

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
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.

### About these Coverage Examples:

- **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): 20%
  - Other: 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:** $12,731

  **In this example, Peg would pay:**
  - Cost Sharing
    - Deductibles: $1,500
    - Copayments: $110
    - Coinsurance: $2,480
  - What isn’t covered
    - Limits or exclusions: $60
  - The total Peg would pay is $4,150

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

### 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): 20%
- Other: 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:** $7,389

  **In this example, Joe would pay:**
  - Cost Sharing
    - Deductibles: $1,989
    - Copayments: $745
    - Coinsurance: $1,268
  - What isn’t covered
    - Limits or exclusions: $55
  - The total Joe would pay is $4,057

### Mia’s Simple Fracture
- (in-network emergency room visit and follow up care)
- The plan’s overall deductible: $1,500
- Specialist: $40
- Hospital (facility): 20%
- Other: 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:** $2,442

  **In this example, Mia would pay:**
  - Cost Sharing
    - Deductibles: $522
    - Copayments: $870
    - Coinsurance: $64
  - What isn’t covered
    - Limits or exclusions: $55
  - The total Mia would pay is $1,456

Healthy Premier Gold Copay SBC 1/1/2020
updated 9/2019