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 801-213-4111 or visit https://uhealthplan.utah.edu/individual/. 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 801-213-4111 to request a copy.

<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>For In-Network Providers: $0/Individual, $0/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 and prescription drugs.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For In-Network Providers: $0/Individual, $0/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 limit 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>Premium, Balance Billing Charges and Health Care this plan does not cover</td>
<td>Even though you pay these expenses they don't count toward 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="https://uhealthplan.utah.edu/individual/">https://uhealthplan.utah.edu/individual/</a> or call 801-213-4111 for a list of network providers.</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>
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For more information about limitations and exceptions, see the plan or policy document at [https://uhealthplan.utah.edu/individual/](https://uhealthplan.utah.edu/individual/)

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<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>
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<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>No Charge</td>
<td>Not covered</td>
<td>None.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>No Charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>Not covered</td>
<td>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.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No Charge</td>
<td>Not covered</td>
<td>Preauthorization may be required for certain services or benefits may be denied.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No Charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>
| Tier 1(Preferred Generic drugs) | Retail: No Charge  
*Deductible* does not apply.  
Mail Order: No Charge  
*Deductible* does not apply. | Retail: Not covered  
Mail Order: Not covered | |
| Tier 2 (Non-Preferred Generic and Preferred Brand Drugs) | Retail: No Charge  
*Deductible* does not apply.  
Mail Order: No Charge  
*Deductible* does not apply. | Retail: Not covered  
Mail Order: Not covered | |
| Tier 3 (Non-Preferred Brand Drugs) | Retail: No Charge  
*Deductible* does not apply.  
Mail Order: Not covered | Retail: Not covered  
Mail Order: Not covered | Retail up to a 30 day supply, Mail Order up to a 90 day supply. Quantity Limits, Step Therapy, and Prior Authorization may apply. Refer to the drug formulary for detailed information. |
| Tier 4 (Specialty drugs) | Retail: No Charge  
*Deductible* does not apply.  
Mail Order: Not covered | Retail: Not covered  
Mail Order: Not covered | |
<p>| <strong>If you have outpatient surgery</strong> | Facility fee (e.g., ambulatory surgery center) | No Charge | Benefits may be denied for failure to obtain preauthorization for certain services. |
| | Physician/surgeon fees | No Charge | Not covered |
| <strong>If you need immediate medical attention</strong> | Emergency room care | No Charge | Copayment is waived if admitted directly to a hospital or facility on an |</p>
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<td>Out-of-Network (You will pay the most)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>Ambulance - Ground: No Charge</td>
<td>Ambulance - Ground: No Charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ambulance - Air: No Charge</td>
<td>Ambulance - Air: No Charge</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>No Charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No Charge</td>
<td></td>
</tr>
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<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: No Charge</td>
<td>Office: Not covered</td>
</tr>
<tr>
<td></td>
<td>Other: No Charge</td>
<td>Other: Not covered</td>
<td></td>
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<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Inpatient services</td>
<td>No Charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No Charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No Charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No Charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No Charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No Charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Habilitation services</td>
<td>No Charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No Charge</td>
<td>Not covered</td>
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</tr>
<tr>
<td>Durable medical equipment</td>
<td>No Charge</td>
<td>Not covered</td>
<td>Preauthorization may be required for certain services.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No Charge</td>
<td>Not covered</td>
<td>Prior authorization is required for durable medical equipment over 1000, or services are 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>
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### 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
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Routine eye care 1 Visits 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 801-213-4111, 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](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](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: Customer Service at 801-213-4111. 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 individual 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 Services:

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 801-213-4111 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801-213-4111 TTY: 1-800-346-4128.


**Korean:** 한국어를 사용하시는 경우, 전화不通요 언어 지원 서비스를 무료로 이용하실 수 있습니다. 801-213-4111 TTY: 1-800-346-4128

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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: $0.00
  - Specialist copayment: $0.00
  - Hospital (facility) copayment: $0.00
  - Other copayment: $0.00
  - 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:
    - Deductibles: $0.00
    - Copayments: $0.00
    - Coinsurance: $0.00
    - What isn’t covered:
      - Limits or exclusions: $50.00
      - The total Peg would pay is: $50.00

- **Managing Joe’s type 2 Diabetes**
  - A year of routine in-network care of a well-controlled condition
  - The plan’s overall deductible: $0.00
  - Specialist copayment: $0.00
  - Hospital (facility) copayment: $0.00
  - Other copayment: $0.00
  - 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:
    - Deductibles: $0.00
    - Copayments: $0.00
    - Coinsurance: $0.00
    - What isn’t covered:
      - Limits or exclusions: $20.00
      - The total Joe would pay is: $20.00

- **Mia’s Simple Fracture**
  - In-network emergency room visit and follow up care
  - The plan’s overall deductible: $0.00
  - Specialist copayment: $0.00
  - Hospital (facility) copayment: $0.00
  - Other copayment: $0.00
  - 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:
    - Deductibles: $0.00
    - Copayments: $0.00
    - Coinsurance: $0.00
    - What isn’t covered:
      - Limits or exclusions: $0.00
      - The total Mia would pay is: $0.00

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