### Important Questions

<table>
<thead>
<tr>
<th>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: $3,000/Individual, $6,000/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 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>Yes, $500/individual or $1,000/family for prescription drugs.</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>For In-Network Providers: $6,550/Individual, $13,100/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>
</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><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network (You will pay the least): $30 copay/Per Visit Deductible does not apply.</td>
<td>Out-of-Network (You will pay the most): Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$60 copay/Per Visit Deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<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>Diagnostic test (x-ray, blood work)</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1(Preferred Generic drugs)</td>
<td>Retail: $15 copay/Per Medication Deductible does not apply. Mail Order: $30 copay/Per Medication Deductible does not apply.</td>
<td>Retail: Not covered Mail Order: Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Non-Preferred Generic and Preferred Brand Drugs)</td>
<td>Retail: $30 copay/Per Medication Deductible does not apply. Mail Order: $60 copay/Per Medication Deductible does not apply.</td>
<td>Retail: Not covered Mail Order: Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3 (Non-Preferred Brand Drugs)</td>
<td>Retail: 50% coinsurance Mail Order: Not covered</td>
<td>Retail: Not covered Mail Order: Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 4 (Specialty drugs)</td>
<td>Retail: 25% coinsurance Mail Order: Not covered</td>
<td>Retail: Not covered Mail Order: Not covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* 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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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network (You will pay the least)</td>
<td>Out-of-Network (You will pay the most)</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td></td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Emergency room care</td>
<td></td>
<td>$250 copay/Per Visit</td>
<td>$250 copay/Per Visit</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>Ambulance - Ground: $250 copay/Per Visit</td>
<td>Ambulance - Air: 30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>$30 copay/Per Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td></td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td></td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td>Office: $30 copay/Per Visit Deductible</td>
<td>Office: Not covered</td>
<td>Other: Not covered</td>
</tr>
<tr>
<td>Inpatient services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>$30 copay/Per Visit Deductible does not apply.</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td></td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td></td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Habilitation services</td>
<td></td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
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<tr>
<td></td>
<td></td>
<td>In-Network (You will pay the least)</td>
<td>Out-of-Network (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td></td>
<td>failure to obtain preauthorization for certain services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SNF and Acute Rehab Limited to 30 Days per calendar year each. Long Term Acute Care unlimited. Preauthorization may be required for certain services.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td></td>
<td>Prior authorization is required for durable medical equipment over $1000, or services are not covered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Limited to 6 Months in every 3 years. Prior authorization is required or benefits may be denied.</td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></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>One set of corrective lenses per year. Frames are not covered.</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 [https://uhealthplan.utah.edu/individual/]
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
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<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Dental care (Adult)</td>
<td>Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>Hearing aids</td>
<td>Private-duty nursing</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>Infertility treatment</td>
<td>Routine foot care</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td>Long-term care</td>
<td>Weight loss programs</td>
</tr>
</tbody>
</table>

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. 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 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 Servicesss:


Korean: 801-213-4111 TTY: 1-800-346-4128

* For more information about limitations and exceptions, see the plan or policy document at https://uhealthplan.utah.edu/individual/
To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at https://uhealthplan.utah.edu/individual/
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**: $3,000.00
- **Specialist copayment**: $60.00
- **Hospital (facility) coinsurance**: 30.00%
- **Other coinsurance**: 30.00%

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**: $12,800

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,000.00</td>
</tr>
<tr>
<td>Copayments</td>
<td>$30.00</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,900.00</td>
</tr>
</tbody>
</table>

**What isn’t covered**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

**The total Peg would pay is**: $5,900.00

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

- **The plan’s overall deductible**: $3,000.00
- **Specialist copayment**: $60.00
- **Hospital (facility) coinsurance**: 30.00%
- **Other coinsurance**: 30.00%

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**: $7,400

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$900.00</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400.00</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,500.00</td>
</tr>
</tbody>
</table>

**What isn’t covered**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$20.00</td>
</tr>
</tbody>
</table>

**The total Joe would pay is**: $2,900.00

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

- **The plan’s overall deductible**: $3,000.00
- **Specialist copayment**: $60.00
- **Hospital (facility) coinsurance**: 30.00%
- **Other coinsurance**: 30.00%

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**: $1,900

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,400.00</td>
</tr>
<tr>
<td>Copayments</td>
<td>$100.00</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**What isn’t covered**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**The total Mia would pay is**: $2,500.00

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