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 deductible?	**Network Providers:** **$6,000**/individual or **$12,000**/family	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.
Are there services covered before you meet your deductible?	**Yes,** preventive care, office visits	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.
Are there other deductibles for specific services?	**Yes, $500**/individual or **$1,000**/family for prescription drug	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.
What is the out-of-pocket limit for this plan?	**Network Providers:** **$7,150**/individual or **$14,300**/family	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count towards the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes,** See http://uhealthplan.utah.edu/individual/providers.php or call 1-888-271-5870	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.
Do you need a referral to see a specialist?	**No**	You can see the specialist you choose 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
		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	$45 Copayment deductible waived	Not Covered	Amount for the first 3 PCP/Mental Health office visits combined per calendar year.
	Specialist visit	60% Coinsurance	Not Covered	None
	Preventive care/screening/ immunization	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	Diagnostic test (x-ray, blood work)	60% Coinsurance	Not Covered	Benefits may be denied for failure to obtain preauthorization for certain services.
	Imaging (CT/PET scans, MRIs)	60% 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 **prescription drug coverage** is available at http://uhealthplan.utah.edu/individual/pharmacy.php	Tier 1 (Preferred Generic Drugs)	$35 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)	60% Coinsurance	Not Covered	
	Tier 3 (Non-Preferred Brand Drugs)	60% Coinsurance	Not Covered	
	Tier 4 (Specialty drugs)	60% 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.

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

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	60% Coinsurance	Not Covered	Benefits may be denied for failure to obtain preauthorization for certain services.
	Physician/surgeon fees	60% Coinsurance	Not Covered	Benefits may be denied for failure to obtain preauthorization for certain services.
If you need immediate medical attention	Emergency room care	60% Coinsurance	60% coinsurance	Emergency room services apply to network provider benefits.
	Emergency medical transportation	60% Coinsurance	60% coinsurance	Emergency medical transportation applies to network provider benefits.
	Urgent care	60% Coinsurance	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	60% Coinsurance	Not Covered	Benefits may be denied for failure to obtain preauthorization for certain services.
	Physician/surgeon fees	60% Coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$45 Copayment deductible waived	Not Covered	Amount for the first 3 PCP/Mental Health office visits combined per calendar year. Benefits may be denied for failure to obtain preauthorization for certain services. Additional limitations and exclusions apply.
	Inpatient services	60% Coinsurance	Not Covered	
If you are pregnant	Office visits	See PCP/SCP	Not Covered	Notify U Baby care team for care management services at 1-888-271-5870. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	60% Coinsurance	Not Covered	
	Childbirth/delivery facility services	60% Coinsurance	Not Covered	

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

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 need help recovering or have other special health needs	Home health care	60% Coinsurance	Not Covered	Limited to 30 visits per year. Prior authorization is required, or services are not covered.
	Rehabilitation services	60% Coinsurance	Not Covered	Limited to 20 visits per year total for both rehabilitation and habilitation services. Benefits may be denied for failure to obtain preauthorization for certain services.
	Habilitation services	60% Coinsurance	Not Covered	
	Skilled nursing care	60% Coinsurance	Not Covered	Limited to 30 days per year. Benefits may be denied for failure to obtain preauthorization for certain services.
	Durable medical equipment	60% Coinsurance	Not Covered	Prior authorization is required for durable medical equipment over $750, or services are not covered.
	Hospice services	60% 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 Covered

* 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
- Attention-Deficit/Hyperactivity Disorder
- 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
- Prosthetics

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 1-888-271-5870, 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 1-888-271-5870. 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

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: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de University of Utah Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-271-5870.

Chinese : 如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 University of Utah Health Plans
方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字1-888-271-5870。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về University of Utah Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-888-271-5870.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 University of Utah Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-888-271-5870로 전화하십시오.

Navajo: Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-271-5870.

Nepali: यदि तपाईं आफ्ना लादि आफैं आवेिनको काम ििै, वा कसैलाई मद्दत ििै हुनुहुन्छ, University of Utah Health Plans बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा दन:शुल्क सहायता वा जानकारी पाउने अदिकार छ । ोभाषे (इन्टरप्रेटर) सँि कुरा िनुपरे 1-888-271-5870 मा फोन िनुहोस् ।

Tongan: ‘O kapau ‘oku i ai ha’o fehu’i, pe ha fehu’i mei ha tokotaha ‘oku ke tokoni ki ai, ‘o kau ki he University of Utah Health Plans, ‘oku ke ma’u ‘a e totonu ke ma’u ha fakahinohino mo e tokoni ‘i ho’o lea fakafonua ta’etotongi. Ke talanoa mo ha tokotaha fakatonu lea, tā ki he fika ko ‘eni 1-888-271-5870.

Serbo-Croation: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o University of Utah Health Plans, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-888-271-5870.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa University of Utah Health Plans, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-888-271-5870.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum University of Utah Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-271-5870 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу University of Utah Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-888-271-5870.

Arabic: إن كان لديك أو لدى شخص تساعده بخصوص أسئلة University of Utah Health Plans ، فلديك الحق في الحصول على المساعدة والمعلومات المتاحة بلغتك الضرورية دون مقابل. اتصل مترجم لتتحدث. 1-888-271-5870.

Mon-Khmer, Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងដែជួយ ម្នាសំណួរអ្ំពី University of Utah Health Plans បេ, អ្នកម្នាសិេធិេេួលជំនួយនិងព័ែ៌ម្នាន ជៅកនុងភាសា ររស់អ្នក ជោយមិនអ្ស់ប្ាក់ ។ បេើមបីនិយាយជាមួយអ្នកែកប្រ សូម 1-888-271-5870. ។

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

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de University of Utah Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-888-271-5870.

Japanese: ご本人様、またはお客様の身の回りの方でも、University of Utah Health Plans name]についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-888-271-5870までお電話ください。

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 www.uhealthplan.utah.edu.

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	$6,000
Specialist	60%
Hospital (facility)	60%
Other	60%

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,039
Copayments	$140
Coinsurance	$1,971
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,210**

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

The plan's overall deductible	$6,000
Specialist	60%
Hospital (facility)	60%
Other	60%

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,670
Copayments	$1,085
Coinsurance	$3,905
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$6,715**

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

The plan's overall deductible	$6,000
Specialist	60%
Hospital (facility)	60%
Other	60%

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$770
Copayments	$0
Coinsurance	$1155
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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