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, contact University of Utah Health Insurance Plans at (833) 981-0213. 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.uhealthplan.utah.edu/lf-members or call (833) 981-0213 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | For in-network providers:<br>$4000 Per Person, $8000 Family<br>For out-of-network providers:<br>Not Covered | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay for covered services. Check your policy or plan document to see when the deductible starts over. See the chart starting on page 3 for how much you pay for covered services after you meet the deductible. |
| Are there services covered before you meet your deductible? | Yes | 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. |
| Are there other deductibles for specific services? | No | 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? | For in-network providers:<br>$6000 Per Person, $12000 Family<br>For out-of-network providers:<br>Not Covered | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billed charges and health care this plan doesn't cover. | Even though you pay for these expenses, they don't count toward the out-of-pocket limit. |
| Will you pay less if you use a network provider? | Yes. For a list of in-network providers visit www.uhealthplan.utah.edu or call 1-(833) 981-0213. | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participation for providers in their network. See the chart starting on page 3 for how this plan pays different kinds of providers. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without permission from this plan. |

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 | Deductible, then 30% Coinsurance | Not Covered | ---None--- |
| | Specialist visit | Deductible, then 30% Coinsurance | Not Covered | ---None--- |
| | Preventive care/screening/ immunization | No Charge | Not Covered | Refer to the plan document for a complete list of preventative services. |
| If you have a test | Diagnostic test (x-ray, blood work) | Deductible, then 30% Coinsurance | Not Covered | Preauthorization may be required for certain services. |
| | Imaging (CT/PET scans, MRIs) | Deductible, then 30% Coinsurance | Not Covered | |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.uhealthplans.utah.edu | Preferred generic drugs<br>30 day supply<br>90 day supply -Mail order | Deductible, then 30% Coinsurance | Not Covered | Quantity Limits, Step Therapy, and Prior Authorization may apply. Refer to the drug formulary for detailed information. |
| | Preferred brand drugs<br>30 day supply<br>90 day supply -Mail order | Deductible, then 30% Coinsurance | Not Covered | |
| | Non-preferred brand drugs –<br>30 day supply<br>90 day supply -Mail order | Deductible, then 30% Coinsurance | Not Covered | |
| | Specialty drugs - *Must use University of Utah Specialty Pharmacy* – 30 day supply only | Deductible, then 30% Coinsurance | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Deductible, then 30% Coinsurance | Not Covered | Preauthorization may be required for certain services. |
| | Physician/surgeon fees | Deductible, then 30% Coinsurance | Not Covered | |
| If you need immediate medical attention | Emergency room care | Deductible, then 30% Coinsurance | Deductible, then 30% Coinsurance | Copayment is waived if admitted directly to a hospital or facility on an inpatient basis. |
| | Emergency medical transportation | Deductible, then 30% Coinsurance | Deductible, then 30% Coinsurance | Non-emergency use is not covered. |
| | Urgent care | Deductible, then 30% Coinsurance | Not Covered | ---None--- |

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

| 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 a hospital stay | Facility fee (e.g., hospital room) | Deductible, then 30% Coinsurance | Not Covered | Preauthorization may be required for certain services. |
| | Physician/surgeon fees | Deductible, then 30% Coinsurance | Not Covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Deductible, then 30% Coinsurance | Not Covered | Preauthorization may be required for certain services. |
| | Inpatient services | Deductible, then 30% Coinsurance | Not Covered | |
| If you are pregnant | Office visits | Deductible, then 30% Coinsurance | Not Covered | Preauthorization may be required for certain services. |
| | Childbirth/delivery professional services | Deductible, then 30% Coinsurance | Not Covered | |
| | Childbirth/delivery facility services | Deductible, then 30% Coinsurance | Not Covered | |
| If you need help recovering or have other special health needs | Home health care | Deductible, then 30% Coinsurance | Not Covered | Limited to 60 visits per year. Prior authorization is required. |
| | Rehabilitation services | Deductible, then 30% Coinsurance | Not Covered | Limited to 40 visits per year total for both rehabilitation and habilitation services. Preauthorization may be required for certain services. |
| | Habilitation services | Deductible, then 30% Coinsurance | Not Covered | |
| | Skilled nursing care | Deductible, then 30% Coinsurance | Not Covered | Limited to 60 days per year. Preauthorization may be required for certain services. |
| | Durable medical equipment | Deductible, then 30% Coinsurance | Not Covered | Prior authorization is required for durable medical equipment over $5000. |
| | Hospice services | Deductible, then 30% Coinsurance | Not Covered | Prior authorization is required. |
| If you need dental or eye care | Eye exam | No Charge | Not Covered | Limited to one routine eye exam per plan year. |
| | Glasses | Not Covered | Not Covered | Not Applicable |
| | Dental check-up | Not Covered | Not Covered | Not Applicable |

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

## 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
- Private Duty Nursing
- Cosmetic Surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Dental Care
- Hearing aids
- 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
- ABA Therapy for Autism

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: Office of the Superintendent of Insurance 1-801-538-3077. 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: University of Utah Health Plans, Attention: Appeals Coordinator, P.O. Box 45180, Salt Lake City, UT 84145, Customer Service (833) 981-0213

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 (Español): Para obtener asistencia en Español, llame al (833) 981-0213.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (833) 981-0213.

Chinese (中文): 如果需要中文的帮助， ☒☒打☒个号(833) 981-0213.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (833) 981-0213.

*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/lf-members.

## 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 | $4000 |
| Specialist Copayment | 30% |
| Hospital (facility) Coinsurance | 30% |
| Other Coinsurance | 30% |

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 | $7,500 |

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $2408 |
| Copayments | $0 |
| Coinsurance | $3592 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $6060 |

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

| | |
|---|---|
| The plan's overall deductible | $4000 |
| Specialist Copay | 30% |
| Hospital (facility) Coinsurance | 30% |
| Other Coinsurance | 30% |

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 | $5,400 |

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $4000 |
| Copayments | $0 |
| Coinsurance | $2000 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| The total Joe would pay is | $6055 |

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

| | |
|---|---|
| The plan's overall deductible | $4000 |
| Specialist Copayment | 30% |
| Hospital (facility) Coinsurance | 30% |
| Other Coinsurance | 30% |

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 | $4780 |

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $1348 |
| Copayments | $0 |
| Coinsurance | $578 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $1925 |

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