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 833-661-3915 or visit https://uhealthplan.utah.edu/carsontahoe/. 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 833-661-3915 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	For CTHS Providers: $1,000/Individual, $2,000/Family For In-Network Providers: $1,500/Individual, $3,000/Family For Out-of-Network Providers: $3,000/Individual, $6,000/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 and prescription drugs.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**Yes, $50**//person for prescription drugs	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 CTHS and In-Network Providers: $6,850/Individual, $13,700/Family For Out-of-Network Providers: $12,000/Individual, $24,000/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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, Balance Billing Charges and Health Care this plan does not cover	Even though you pay these expenses they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://uhealthplan.utah.edu/carsontahoe/ or call 833-661-3915 for a list of network providers.	You pay the least if you use a provider in CTHS. You pay more if you use a provider in In-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
		CTHS (You will pay the least)	In-Network (You will pay the least)	Out-of-Network (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	$25 copay/Per Visit Deductible does not apply.	$35 copay/Per Visit Deductible does not apply.	50% coinsurance	None.
	Specialist visit	$40 copay/Per Visit Deductible does not apply.	$50 copay/Per Visit Deductible does not apply.	50% coinsurance	None
	Preventive care/screening/immunization	No Charge	No Charge	50% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	50% coinsurance	Preauthorization may be required for certain services or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://uhealthplan.utah.edu/individual/pharmacy.php	Tier 1(Preferred Generic drugs)	**Retail:** $15 copay/Per Medication Deductible does not apply. **Mail Order:** $30 copay/Per Medication Deductible does not apply.	**Retail:** $15 copay/ Per Medication Deductible does not apply. **Mail Order:** $30 copay/ Per Medication Deductible does not apply.	**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 2 (Non-Preferred Generic and Preferred Brand Drugs)	**Retail:** $30 copay/Per Medication	**Retail:** $30 copay/Per Medication	**Retail:** Not covered **Mail Order:** Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		CTHS (You will pay the least)	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
		Deductible does not apply. **Mail Order:** $60 copay/Per Medication Deductible does not apply.	Deductible does not apply. **Mail Order:** $60 copay/Pet Medication Deductible does not apply.		
	Tier 3 (Non-Preferred Brand Drugs)	**Retail:** $60 copay/ Per Medication Deductible does not apply. **Mail Order:** Not covered	**Retail:** $60 copay/ Per Medication Deductible does not apply. **Mail Order:** Not Covered	**Retail:** Not covered **Mail Order:** Not covered	
	Tier 4 (Specialty drugs)	**Retail:** 20% coinsurance **Mail Order:** Not covered	**Retail:** 20% coinsurance **Mail Order:** Not covered	**Retail:** Not covered **Mail Order:** Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	50% coinsurance	Benefits may be denied for failure to obtain preauthorization for certain services.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$200 copay/Per Visit Deductible does not apply.	30% coinsurance	30% coinsurance	**Copayment** is waived if admitted directly to a hospital or facility on an inpatient basis. Emergency room services apply to network provider benefits.
	Emergency medical transportation	**Ambulance - Ground:** Not applicable **Ambulance - Air:** Not applicable	**Ambulance - Ground:** $100 copay/Per Visit Deductible does not apply. **Ambulance - Air:** 30% coinsurance	**Ambulance - Ground:** $100 copay/Per Visit Deductible does not apply. **Ambulance - Air:** 30% coinsurance	Non-emergency use is not covered.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		CTHS (You will pay the least)	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
	Urgent care	$40 copay/Per Visit Deductible does not apply.	$50 copay/Per Visit Deductible does not apply.	50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization may be required for certain services or benefits may be denied.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office:** $40 copay/Per Visit Deductible does not apply. **Other:** 20% coinsurance	**Office:** $50 copay/Per Visit Deductible does not apply. **Other:** 30% coinsurance	**Office:** 50% coinsurance **Other:** 50% coinsurance	Preauthorization may be required for certain services or benefits may be denied. Additional limitations and exclusions apply.
	Inpatient services	20% coinsurance	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	$25 copay/Per Visit Deductible does not apply.	$35 copay/Per Visit Deductible does not apply.	50% coinsurance	Notify U Baby care team for care management services at 1-833-981-0214. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization may be required for certain services or benefits may be denied.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	Not applicable	30% coinsurance	50% coinsurance	Limted to 60 Visits per calendar year. Prior authorization is required, or services are not covered.
	Rehabilitation services	20% coinsurance	30% coinsurance	50% coinsurance	Limited to 30 Visits per calendar year each for rehabilitation and habilitation services. Benefits may be denied for failure to obtain preauthorization for certain services.
	Habilitation services	20% coinsurance	30% coinsurance	50% coinsurance	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		CTHS (You will pay the least)	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
	Skilled nursing care	Not Applicable	30% coinsurance	50% coinsurance	SNF, Acute Rehab, and Long Term Acure Care Limited to 120 Days per calendar year each. Preauthorization may be required for certain services.
	Durable medical equipment	Not applicable	30% coinsurance	50% coinsurance	Preauthorization may be required for certain services or benefits may be denied.
	Hospice services	20% coinsurance	30% coinsurance	50% coinsurance	Prior authorization is required or benefits may be denied.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not Applicable.
	Children's glasses	Not covered	Not covered	Not covered	Not Applicable.
	Children's dental check-up	Not covered	Not covered	Not covered	Not Applicable.

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.)		
• Dental Care	• Long Term Care	• Routine eye exam
• Hearing aids	• Non-emergency care when traveling outside the U.S.	• Routine foot care
• Infertility Treatment	• Private Duty Nursing	Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• AcupunctureDental care (Adult)	• Bariatric SurgeryLong-term care	• Temporomandibular Joint Dysfunction Treatment (TMJ)
• Chiropractic Care		

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 833-661-3915, your state insurance department, the U.S. Department of Labor's Employee Benefits SecurityAdministration 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 833-661-3915. You may also contact the Utah Insurance Department, Office of Consumer Assistance, 4315 S 2700 W, Suite 2300, Taylorsville, UT 84129. 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 indivdiual 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:

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 833-661-3915 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 833-661-3915 TTY: 1-800-346-4128.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụhỗtrợngôn ngữmiễn phí dành cho bạn. Gọi số833-661-3915 TTY: 1-800-346-4128.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 833-661-3915 TTY: 1-800-346-4128 번으로 전화해 주십시오.

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

Navajo: Dii baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 833-661-3915 TTY: 1- 800-346-4128.

Nepali: Nēpālī: Dhyāna: Yadi tapā'ī spēniśa bōlnuhuncha bhanē, tapā'īnsamga ni: Śulka bhā ā sahayōga sēvāharū chan. Kala garnuhōs 833-661-3915 TTY: 1-800-346-4128.

Tongan: FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai1 833-661-3915 TTY: 1-800-346-4128.

Serbo-Croation: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 833-661-3915 TTY: 1-800-346- 4128.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 833-661-3915 TTY: 1-800-346-4128.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 833-661-3915 TTY: 1- 800-346-4128.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 833-661-3915 (телетайп: 1-800-346-4128).

Arabic: alearabiat: tanbih: 'iidha kunt tatahadath al'iisbaniat , faladik khadamat musaeadat lighawyat majaniat. 'atasil bialraqm 833-661-3915 TTY: 1-800-346-4128.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 833-661-3915 (ATS: 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。833-661-3915 (TTY: 1-800-346-4128) まで、お電話にてご連絡ください。

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

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	$1,000.00
Specialist copayment	$40.00
Hospital (facility) coinsurance	20.00%
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:

Cost Sharing	
Deductibles	$1,000.00
Copayments	$30.00
Coinsurance	$2,000.00
What isn't covered	
Limits or exclusions	$50.00
The total Peg would pay is	**$3,080.00**

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

The plan's overall deductible	$1,000.00
Specialist copayment	$40.00
Hospital (facility) coinsurance	20.00%
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:

Cost Sharing	
Deductibles	$50.00
Copayments	$1,400.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$300.00
The total Joe would pay is	**$1,750.00**

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

The plan's overall deductible	$1,000.00
Specialist copayment	$40.00
Hospital (facility) coinsurance	20.00%
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:

Cost Sharing	
Deductibles	$400.00
Copayments	$500.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$1,200.00
The total Mia would pay is	**$2,100.00**

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