



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/>. 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](http://www.healthcare.gov/sbc-glossary) or call 833-661-3915 to request a copy.

Important Questions	Answers	Why This Matters
<b>What is the overall <a href="#">deductible</a>?</b>	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 <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	<b>Yes, \$50</b> //person for prescription drugs	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these <a href="#">services</a>
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For CTHS and In-Network Providers: \$6,850/Individual, \$13,700/Family For Out-of-Network Providers: \$12,000/Individual, \$24,000/Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Premium, Balance Billing Charges and Health Care this plan does not cover	Even though you pay these expenses they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="https://uhealthplan.utah.edu/">https://uhealthplan.utah.edu/</a> or call 833-661-3915 for a list of <a href="#">network providers</a> .	You pay the least if you use a <a href="#">provider</a> in CTHS. You pay more if you use a <a href="#">provider</a> in In-Network. You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No	You can see the <a href="#">specialist</a> 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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /Per Visit <a href="#">Deductible</a> does not apply.	\$35 <a href="#">copay</a> /Per Visit <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /Per Visit <a href="#">Deductible</a> does not apply.	\$50 <a href="#">copay</a> /Per Visit <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening</a> /immunization	No Charge	No Charge	50% <a href="#">coinsurance</a>	Frequency limitations apply. Deductible does not apply. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	No Charge	50% <a href="#">coinsurance</a>	Preauthorization may be required for certain services or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="https://uhealthplan.utah.edu/individual/pharmacy.php">https://uhealthplan.utah.edu/individual/pharmacy.php</a>	Tier 1(Preferred Generic drugs)	<b>Retail:</b> \$15 <a href="#">copay</a> /Per Medication <a href="#">Deductible</a> does not apply. <b>Mail Order:</b> \$30 <a href="#">copay</a> /Per Medication <a href="#">Deductible</a> does not apply.	<b>Retail:</b> \$15 <a href="#">copay</a> /Per Medication <a href="#">Deductible</a> does not apply. <b>Mail Order:</b> \$30 <a href="#">copay</a> /Per Medication <a href="#">Deductible</a> does not apply.	<b>Retail:</b> Not covered <b>Mail Order:</b> 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)	<b>Retail:</b> \$30 <a href="#">copay</a> /Per Medication	<b>Retail:</b> \$30 <a href="#">copay</a> /Per Medication	<b>Retail:</b> Not covered <b>Mail Order:</b> Not covered	

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

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)	
		<u>Deductible</u> does not apply. <b>Mail Order:</b> \$60 <u>copay</u> /Per Medication <u>Deductible</u> does not apply.	<u>Deductible</u> does not apply. <b>Mail Order:</b> \$60 <u>copay</u> /Pet Medication <u>Deductible</u> does not apply.		
	Tier 3 (Non-Preferred Brand Drugs)	<b>Retail:</b> \$60 <u>copay</u> /Per Medication <u>Deductible</u> does not apply. <b>Mail Order:</b> Not covered	<b>Retail:</b> \$60 <u>copay</u> /Per Medication <u>Deductible</u> does not apply. <b>Mail Order:</b> Not Covered	<b>Retail:</b> Not covered <b>Mail Order:</b> Not covered	
	Tier 4 ( <u>Specialty drugs</u> )	<b>Retail:</b> 20% <u>coinsurance</u> <b>Mail Order:</b> Not covered	<b>Retail:</b> 20% <u>coinsurance</u> <b>Mail Order:</b> Not covered	<b>Retail:</b> Not covered <b>Mail Order:</b> Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Benefits may be denied for failure to obtain preauthorization for certain services.
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$200 <u>copay</u> /Per Visit <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<b>Copayment</b> is waived if admitted directly to a hospital or facility on an inpatient basis. Emergency room services apply to network provider benefits.
	<u>Emergency medical transportation</u>	<b>Ambulance - Ground:</b> Not applicable <b>Ambulance - Air:</b> Not applicable	<b>Ambulance - Ground:</b> \$100 <u>copay</u> /Per Visit <u>Deductible</u> does not apply. <b>Ambulance - Air:</b> 30% <u>coinsurance</u>	<b>Ambulance - Ground:</b> \$100 <u>copay</u> /Per Visit <u>Deductible</u> does not apply. <b>Ambulance - Air:</b> 30% <u>coinsurance</u>	Non-emergency use is not covered.

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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)	
	<a href="#">Urgent care</a>	\$40 <a href="#">copay</a> /Per Visit <a href="#">Deductible</a> does not apply.	\$50 <a href="#">copay</a> /Per Visit <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Preauthorization may be required for certain services or benefits may be denied.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<b>Office:</b> \$40 <a href="#">copay</a> /Per Visit <a href="#">Deductible</a> does not apply. <b>Other:</b> 20% <a href="#">coinsurance</a>	<b>Office:</b> \$50 <a href="#">copay</a> /Per Visit <a href="#">Deductible</a> does not apply. <b>Other:</b> 30% <a href="#">coinsurance</a>	<b>Office:</b> 50% <a href="#">coinsurance</a> <b>Other:</b> 50% <a href="#">coinsurance</a>	Preauthorization may be required for certain services or benefits may be denied. Additional limitations and exclusions apply.
	Inpatient services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	\$25 <a href="#">copay</a> /Per Visit <a href="#">Deductible</a> does not apply.	\$35 <a href="#">copay</a> /Per Visit <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	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% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Not applicable	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 60 Visits per calendar year. Prior authorization is required, or services are not covered.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	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.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

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

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)	
	<a href="#">Skilled nursing care</a>	Not Applicable	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	SNF, Acute Rehab, and Long Term Acure Care Limited to 120 Days per calendar year each. Preauthorization may be required for certain services.
	<a href="#">Durable medical equipment</a>	Not applicable	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Preauthorization may be required for certain services or benefits may be denied.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Prior authorization is required or benefits may be denied.
<b>If your child needs dental or eye care</b>	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.

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

Nepali: Nēpālī: Dhyāna: Yadi tapāṭī spēniśa bōlnuhuncha bhanē, tapāṭīnsamga 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 mai 833-661-3915 TTY: 1-800-346-4128.

Serbo-Croatian: 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。

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*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
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$0

**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
Copayments	\$10
Coinsurance	\$2,300
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,370</b>

**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
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$0

**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	\$900
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,520</b>

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$0

**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	\$1,000
Copayments	\$500
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,600</b>