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 1-833-981-0214 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Network Providers:** **$6,550**/individual or **$13,100**/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. As an example one adult annual routine eye exam is covered as preventive.
Are there other deductibles for specific services?	**Yes,** prescription drug deductible combined with medical	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:** **$8,150**/individual or **$16,300**/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 1-833-981-0214	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, then 40% Coinsurance	Not Covered	Amount for the first 3 PCP/Mental Health office visits combined per calendar year.
	Specialist visit	40% 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)	40% Coinsurance	Not Covered	Benefits may be denied for failure to obtain preauthorization for certain services.
	Imaging (CT/PET scans, MRIs)	40% 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)	40% Coinsurance	Not Covered	
	Tier 3 (Non-Preferred Brand Drugs)	50% Coinsurance	Not Covered	
	Tier 4 (Specialty drugs)	40% 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.

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)	40% Coinsurance	Not Covered	Benefits may be denied for failure to obtain preauthorization for certain services.
	Physician/surgeon fees	40% Coinsurance	Not Covered	Benefits may be denied for failure to obtain preauthorization for certain services.
If you need immediate medical attention	Emergency room care	40% Coinsurance	40% coinsurance	Emergency room services apply to network provider benefits.
	Emergency medical transportation	40% Coinsurance	40% coinsurance	Emergency medical transportation applies to network provider benefits.
	Urgent care	$45 Copayment deductible waived, then 40% Coinsurance	Not Covered	Copay amount for the first 3 Urgent Care visits per calendar year.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% Coinsurance	Not Covered	Benefits may be denied for failure to obtain preauthorization for certain services.
	Physician/surgeon fees	40% Coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$45 Copayment deductible waived, then 40% Coinsurance Other: 40% Coinsurance	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.
	Inpatient services	40% Coinsurance	Not Covered	Additional limitations and exclusions apply.
If you are pregnant	Office visits	$45 Copayment deductible waived, then 40% Coinsurance	Not Covered	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).
	Childbirth/delivery professional services	40% Coinsurance	Not Covered	
	Childbirth/delivery facility services	40% Coinsurance	Not Covered	

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	40% Coinsurance	Not Covered	Limited to 30 visits per year. Prior authorization is required, or services are not covered.
	Rehabilitation services	40% Coinsurance	Not Covered	Limited to 20 visits per year total for each rehabilitation and habilitation services. Benefits may be denied for failure to obtain preauthorization for certain services.
	Habilitation services	40% Coinsurance	Not Covered	
	Skilled nursing care	40% Coinsurance	Not Covered	Limited to 30 days per year. SNF and LTAC have a combined 30 day limit per year. Benefits may be denied for failure to obtain preauthorization for certain services.
	Durable medical equipment	40% Coinsurance	Not Covered	Prior authorization is required for durable medical equipment over $750, or services are not covered.
	Hospice services	40% 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

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
- 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 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 1-833-981-0214, 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 1-833-981-0214. 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**

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: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-981-0214 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1-833-981-0214 TTY: 1-800-346-4128。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-833-981-0214 TTY: 1-800-346-4128.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-833-981-0214 TTY: 1-800-346-4128 번으로 전화해 주십시오.

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 1-833-981-0214 TTY: 1- 800-346-4128.

Nepali: Nēpālī: Dhyāna: Yadi tapā'ī nēpālī bōlnuhuncha bhanē, tapā'īnsamga ni: Śulka bhā ā sahāyatā sēvāharū upalabdha chan. Kala garnuhōs 1-833-981-0214 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 1-833-981-0214 TTY: 1-800-346-4128.

Serbo-Croation: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-833-981-0214 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 1-833-981-0214 TTY: 1-800-346-4128.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-833-981-0214 TTY: 1-800-346-4128.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-833-981-0214 (телетайп: 1-800-346-4128).

Arabic: alearabiat: tanbiha: 'iidha kunt tatahadath alearabiat , faladayk khadamat musaeadat lighawyat majaniat taht tasrfuk. 'atasil bialraqm 1-833-981-0214 TTY: 1-800-346-4128.

Mon-Khmer, Cambodian: ប្រយ័តន៖ បរសនជាអ្ន កន យាយ ភាសខ្មែរ, បសវាជ្នយខុននកភ្សា ប្រយម នគតុឈន ល គឺអ្ចម្ន នស រារំភ្រអន ក។ ច្រ ទរ្ស័ព្ទ 11-833-981-0214 TTY: 1-800-346-4128)។

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-833-981-0214 (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。
1-833-981-0214（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	$6,550
Specialist	40%
Hospital (facility)	40%
Other	40%

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,190
Copayments	$0
Coinsurance	$4,960
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,210**

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

The plan's overall deductible	$6,550
Specialist	40%
Hospital (facility)	40%
Other	40%

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,430
Copayments	$1400
Coinsurance	$2,287
What isn't covered	
Limits or exclusions	$163
The total Joe would pay is	**$7,280**

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

The plan's overall deductible	$6,550
Specialist	40%
Hospital (facility)	40%
Other	40%

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	**$2,442**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$634
Copayments	$750
Coinsurance	$245
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,629**

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