5	verage: What this Plan Covers & What Yons: Healthy Premier Expanded Bronze I	5		
The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u> . The SBC shows you how you and the <u>plan</u> the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u> ) will be provided separat This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 801-213-4111 or visit <u>https://uhealthplan.utah.edu/individual/</u> . For general definitions of common terms, such as <u>allowed amount</u> , <u>balance billing</u> , <u>coinsurance</u> , <u>copayment</u> , <u>d</u> <u>provider</u> , or other <u>underlined</u> terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 801-213-4111 to request a copy				
Important Questions	Answers	Why This Matters		
What is the overall deductible?	For In-Network Providers: \$5,750/Individual, \$11,500/Family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .		
Are there services covered before you meet your <u>deductible</u> ?	Yes, Preventive care 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> .		
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.		
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For In-Network Providers: \$7,000/Individual, \$14,000/Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limit</u> until the overall family <u>out-of-pocket limit</u> 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 <u>network provider</u> ?	Yes. See https://uhealthplan.utah.edu/individual/ or call 801-213-4111 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.		
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a referral.		



All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common		What You	u Will Pay	Limitations Exceptions 9 Other	
Medical Event	Services You May Need	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /Per Visit	Not covered	None.	
	<u>Specialist</u> visit	\$50 <u>copay</u> /Per Visit	Not covered	None	
If you visit a health care provider's office or clinic	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 <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.	
If you have a tast	Diagnostic test (x-ray, blood work)	35% coinsurance	Not covered	Preauthorization may be required for	
If you have a test	Imaging (CT/PET scans, MRIs)	35% coinsurance	Not covered	certain services or benefits may be denied.	
If you need drugs to treat your illness or	Tier 1(Preferred Generic drugs)	Retail: 35% <u>coinsurance</u> Mail Order: 35% <u>coinsurance</u>	Retail: Not covered Mail Order: Not covered	Datailum ta a 20 day aynaly. Mail Ordar	
condition More information about prescription drug	Tier 2 (Non-Preferred Generic and Preferred Brand Drugs)	Retail: 35% <u>coinsurance</u> Mail Order: 35% <u>coinsurance</u>	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	
coverage is available at https://uhealthplan.utah.ed	Tier 3 (Non-Preferred Brand Drugs)	Retail: 35% coinsurance Mail Order: Not covered	Retail: Not covered Mail Order: Not covered	may apply. Refer to the drug formulary for detailed information.	
u/individual/pharmacy.php	Tier 4 (Specialty drugs)	Retail: 35% coinsurance Mail Order: Not covered	Retail: Not covered Mail Order: Not covered		
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Not covered	Benefits may be denied for failure to obtain preauthorization for certain	
surgery	Physician/surgeon fees	35% <u>coinsurance</u>	Not covered	services.	
If you need immediate medical attention	Emergency room care	35% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Copayment</u> is waived if admitted directly to a hospital or facility on an inpatient basis. Emergency room services apply to network provider benefits.	

Common		What You	ı Will Pay	Limitations, Exceptions, & Other	
Medical Event	Services You May Need	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	Important Information	
	Emergency medical transportation	Ambulance - Ground: 35% <u>coinsurance</u> Ambulance - Air: 35% <u>coinsurance</u>	Ambulance - Ground: 35% <u>coinsurance</u> Ambulance - Air: 35% <u>coinsurance</u>	Non-emergency use is not covered.	
	Urgent care	\$30 <u>copay</u> /Per Visit	Not covered	None.	
lf you have a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance	Not covered	Preauthorization may be required for certain services or benefits may be	
Stay	Physician/surgeon fees	35% <u>coinsurance</u>	Not covered	denied.	
If you need mental health, behavioral	Outpatient services	Office: \$30 <u>copay</u> /Per Visit Other: 35% <u>coinsurance</u>	Office: Not covered Other: Not covered	Preauthorization may be required for certain services or benefits may be	
health, or substance abuse services	Inpatient services	35% coinsurance	Not covered	denied. Additional limitations and exclusions apply.	
	Office visits	\$30 <u>copay</u> /Per Visit	Not covered	Notify U Baby care team for care	
	Childbirth/delivery professional services	35% <u>coinsurance</u>	Not covered	management services at 1-833-981- 0214. Maternity care may include tests	
If you are pregnant	Childbirth/delivery facility services	35% <u>coinsurance</u>	Not covered	and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization may be required for certain services or benefits may be denied.	
	Home health care	35% <u>coinsurance</u>	Not covered	Limted to 30 Visits per calendar year. Prior authorization is required, or services are not covered.	
	Rehabilitation services	35% coinsurance	Not covered	Limited to 20 Visits per calendar year	
If you need help recovering or have other special health needs	Habilitation services	35% <u>coinsurance</u>	Not covered	total for rehabilitation and habilitation services. Benefits may be denied for failure to obtain preauthorization for certain services.	
	Skilled nursing care	35% <u>coinsurance</u>	Not covered	SNF and Acute Rehab Limited to 30 Days per calendar year each. Long Term Acute Care unlimited. Preauthorization may be required for certain services.	

Common		What You	u Will Pay	Limitations Evagations & Other
Medical Event			Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Durable medical equipment	35% <u>coinsurance</u>	Not covered	Prior authorization is required for durable medical equipment over 1000, or services are not covered.
	Hospice services	35% <u>coinsurance</u>	Not covered	Limited to 6 Months in every 3 years. Prior authorization is required or benefits may be denied.
If your shild passes	Children's eye exam	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Limited to one routine eye exam per plan year.
If your child needs dental or eye care	Children's glasses	0% <u>coinsurance</u>	0% <u>coinsurance</u>	One set of corrective lenses per year. Frames are not covered.
	Children's dental check-up	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.)				
Acupuncture     Dental care (Adult)     Non-emergency care when traveling outside the second se				
		U.S.		
Bariatric surgery	<ul> <li>Hearing aids</li> </ul>	<ul> <li>Private-duty nursing</li> </ul>		
Chiropractic care	<ul> <li>Infertility treatment</li> </ul>	<ul> <li>Routine foot care</li> </ul>		
Cosmetic surgery	Long-term care	Weight loss programs		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

• Routine eye care 1 Visits per calendar year

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 801-213-4111, 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Customer Service at 801-213-4111. 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

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 801-213-4111 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 801-213-4111 TTY: 1-800-346-4128.

Vietnamese: CHÚ Ý: Nếu bạo nói Tiếng Việt, có các dịch vự hỗtrọngôn ngữ miễn phí dành cho bạo. Gọi số 801-213-4111 TTY: 1-800-346-4128.

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

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 801-213-4111 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 801-213-4111 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 801-213-4111 TTY: 1-800-346-4128.

Serbo-Croation: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 801-213-4111 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 801-213-4111 TTY: 1-800-346-4128.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 801-213-4111 TTY: 1- 800-346-4128.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 801-213-4111 (телетайп: 1-800-346-4128).

Arabic: alearabiat: tanbih: 'iidha kunt tatahadath al'iisbaniat , faladik khadamat musaeadat lighawyat majaniat. 'atasil bialraqm 801-213-4111 TTY: 1-800-346-4128.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 801-213-4111 (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。801-213-4111 (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.

\$5.750.00

\$5,600

Peg is Having a Bab (9 months of in-network pre-natal hospital delivery)	<u> </u>	Managing Joe's type 2 Dia (a year of routine in-network care controlled condition)	
<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> <li>Specialist <u>copayment</u></li> <li>Hospital (facility) <u>coinsurance</u></li> <li>Other <u>coinsurance</u></li> </ul>	\$5,750.00 \$50.00 35.00% 35.00%	<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> <li>Specialist <u>copayment</u></li> <li>Hospital (facility) <u>coinsurance</u></li> <li>Other <u>coinsurance</u></li> </ul>	\$5,75( \$5( 35.( 35.(
This EXAMPLE event includes serves Specialist office visits (prenatal care)	vices like:	This EXAMPLE event includes serv Primary care physician office visits (in	

\$12,700

Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)

	1 - 1
Specialist <u>copayment</u>	\$50.00
Hospital (facility) <u>coinsurance</u>	35.00%
Other <u>coinsurance</u>	35.00%
This EXAMPLE event includes service	es like:
Primary care physician office visits (incl	uding
disease education)	
Diagnostic tests (blood work)	
Prescription drugs	
Durable medical equipment (alucose m	eter)

## **Total Example Cost**

## In this example, Peg would pay:

**Total Example Cost** 

Cost Sharing			
Deductibles	\$5,750.00		
Copayments	\$0.00		
Coinsurance	\$2,400.00		
What isn't covered			
Limits or exclusions \$50.00			
The total Peg would pay is	\$7,050.00		

In th	is	examp	le, J	loe	wou	ld	pay:	
				~				

Cost Sharing				
Deductibles	\$1,300.00			
Copayments	\$0.00			
Coinsurance	\$1,400.00			
What isn't covered				
Limits or exclusions	\$20.00			
The total Joe would pay is	\$2,720.00			

# Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The <u>plan's</u> overall <u>deductible</u>	\$5,750.00
Specialist <u>copayment</u>	\$50.00
Hospital (facility) coinsurance	35.00%
Other <u>coinsurance</u>	35.00%

#### 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	\$2,800.00		
Copayments	\$0.00		
Coinsurance	\$2.00		
What isn't covered			
Limits or exclusions	\$0.00		
The total Mia would pay is	\$2,802.00		