



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 801-213-4111 or visit <https://uhealthplan.utah.edu/individual/>. 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 801-213-4111 to request a copy.

| Important Questions | Answers | Why This Matters |
|---|---|---|
| What is the overall deductible? | For In-Network Providers: \$0/Individual, \$0/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, \$0/individual or \$0/family 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 In-Network Providers: \$1,500/Individual, \$3,000/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/individual/ or call 801-213-4111 for a list of network providers . | 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 |
|---|--|--|--|---|
| | | 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 | \$10 copay /Per Visit Deductible does not apply. | Not covered | None. |
| | Specialist visit | \$15 copay /Per Visit Deductible does not apply. | 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 you need are preventive . Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 10% coinsurance | Not covered | Preauthorization may be required for certain services or benefits may be denied. |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | Not covered | |
| 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: \$10 copay /Per Medication Deductible does not apply. Mail Order: \$20 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: \$25 copay /Per Medication Deductible does not apply. Mail Order: \$50 copay /Per Medication Deductible does not apply. | Retail: Not covered Mail Order: Not covered | |
| | Tier 3 (Non-Preferred Brand Drugs) | Retail: 5% coinsurance Mail Order: Not covered | Retail: Not covered Mail Order: Not covered | |
| | Tier 4 (Specialty drugs) | Retail: 15% coinsurance Mail Order: Not covered | Retail: Not covered Mail Order: Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | Not covered | |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|--|--|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| | Physician/surgeon fees | 10% coinsurance | Not covered | Benefits may be denied for failure to obtain preauthorization for certain services. |
| If you need immediate medical attention | Emergency room care | \$100 copay /Per Visit | \$100 copay /Per Visit | 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: 10% coinsurance Ambulance - Air: 10% coinsurance | Ambulance - Ground: 10% coinsurance Ambulance - Air: 10% coinsurance | Non-emergency use is not covered. |
| | Urgent care | \$10 copay /Per Visit Deductible does not apply. | Not covered | None. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | Not covered | Preauthorization may be required for certain services or benefits may be denied. |
| | Physician/surgeon fees | 10% coinsurance | Not covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office: \$10 copay /Per Visit Deductible does not apply. Other: 10% coinsurance | Office: Not covered Other: Not covered | Preauthorization may be required for certain services or benefits may be denied. Additional limitations and exclusions apply. |
| | Inpatient services | 10% coinsurance | Not covered | |
| If you are pregnant | Office visits | \$10 copay /Per Visit Deductible does not apply. | 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). Preauthorization may be required for certain services or benefits may be denied. |
| | Childbirth/delivery professional services | 10% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 10% coinsurance | Not covered | |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance | Not covered | Limited to 30 Visits per calendar year. Prior authorization is required, or services are not covered. |
| | Rehabilitation services | \$15 copay /Per Visit | Not covered | Limited to 20 Visits per calendar year total for rehabilitation and habilitation services. Benefits may be denied for |
| | Habilitation services | \$15 copay /Per Visit | Not covered | |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
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| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| | | | | failure to obtain preauthorization for certain services. |
| | Skilled nursing care | 10% coinsurance | 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. |
| | Durable medical equipment | 10% coinsurance | Not covered | Prior authorization is required for durable medical equipment over 1000, or services are not covered. |
| | Hospice services | 10% coinsurance | Not covered | Limited to 6 Months in every 3 years. Prior authorization is required or benefits may be denied. |
| If your child needs dental or eye care | Children's eye exam | No Charge | No Charge | Limited to one routine eye exam per plan year. |
| | 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 Applicable. |

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

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 .) | | |
|---|---|--|
| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Chiropractic care• Cosmetic surgery | <ul style="list-style-type: none">• Dental care (Adult)• Hearing aids• Infertility treatment• Long-term care | <ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Private-duty nursing• Routine foot care• Weight loss programs |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
| <ul style="list-style-type: none">• 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 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 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 individual 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 Services:

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 bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 801-213-4111 TTY: 1-800-346-4128.

Korean: 주의 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 801-213-4111 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/individual/>

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

Nepali: Nēpālī: Dhyāna: Yadi tapāṭī spēniśa bōlnuhuncha bhanē, tapāṭīnsamga 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 mai 801-213-4111 TTY: 1-800-346-4128.

Serbo-Croatian: 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.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---------|
| ■ The plan's overall deductible | \$0.00 |
| ■ Specialist copayment | \$15.00 |
| ■ Hospital (facility) coinsurance | 10.00% |
| ■ Other coinsurance | 10.00% |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|-------------------|
| Deductibles | \$0.00 |
| Copayments | \$20.00 |
| Coinsurance | \$1,300.00 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$50.00 |
| The total Peg would pay is | \$1,370.00 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|---------|
| ■ The plan's overall deductible | \$0.00 |
| ■ Specialist copayment | \$15.00 |
| ■ Hospital (facility) coinsurance | 10.00% |
| ■ Other coinsurance | 10.00% |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|-----------------|
| Deductibles | \$0.00 |
| Copayments | \$300.00 |
| Coinsurance | \$200.00 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20.00 |
| The total Joe would pay is | \$520.00 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$0.00 |
| ■ Specialist copayment | \$15.00 |
| ■ Hospital (facility) coinsurance | 10.00% |
| ■ Other coinsurance | 10.00% |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|-----------------|
| Deductibles | \$0.00 |
| Copayments | \$300.00 |
| Coinsurance | \$100.00 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0.00 |
| The total Mia would pay is | \$400.00 |

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: