



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](http://www.healthcare.gov/sbc-glossary) or call 801-213-4111 to request a copy.

Important Questions	Answers	Why This Matters
<p>What is the overall <a href="#">deductible</a>?</p>	<p><b>For In-Network Providers:</b> \$8,050/Individual, \$16,100/Family</p>	<p>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>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes, Preventive care and prescription drugs.</p>	<p>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>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><b>For In-Network Providers:</b> \$8,050/Individual, \$16,100/Family</p>	<p>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.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p>Premium, Balance Billing Charges and Health Care this plan does not cover</p>	<p>Even though you pay these expenses they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="https://uhealthplan.utah.edu/individual/">https://uhealthplan.utah.edu/individual/</a> or call 801-213-4111 for a list of <a href="#">network providers</a>.</p>	<p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a>. 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.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No</p>	<p>You can see the <a href="#">specialist</a> you choose without a referral.</p>



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	0% <a href="#">coinsurance</a>	Not covered	None.
	<a href="#">Specialist</a> visit	0% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Preventive care/screening</a> /immunization	No Charge	Not covered	Frequency limitations apply. <a href="#">Deductible</a> 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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> may be required for certain services or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	Not covered	
<b>If you need drugs to treat your illness or condition</b> 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> 0% <a href="#">coinsurance</a> <b>Mail Order:</b> 0% <a href="#">coinsurance</a>	<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 <a href="#">Preauthorization</a> may apply. Refer to the drug formulary for detailed information.
	Tier 2 (Non-Preferred Generic and Preferred Brand Drugs)	<b>Retail:</b> 0% <a href="#">coinsurance</a> <b>Mail Order:</b> 0% <a href="#">coinsurance</a>	<b>Retail:</b> Not covered <b>Mail Order:</b> Not covered	
	Tier 3 (Non-Preferred Brand Drugs)	<b>Retail:</b> 0% <a href="#">coinsurance</a> <b>Mail Order:</b> Not covered	<b>Retail:</b> Not covered <b>Mail Order:</b> Not covered	
	Tier 4 ( <a href="#">Specialty drugs</a> )	<b>Retail:</b> 0% <a href="#">coinsurance</a> <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)	0% <a href="#">coinsurance</a>	Not covered	Benefits may be denied for failure to obtain <a href="#">preauthorization</a> for certain services.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	<a href="#">Copay</a> is waived if admitted directly to a hospital or facility on an inpatient basis. Emergency room services apply to network provider benefits.
	<a href="#">Emergency medical transportation</a>	<b>Ambulance - Ground:</b> 0% <a href="#">coinsurance</a>	<b>Ambulance - Ground:</b> 0% <a href="#">coinsurance</a>	Non-emergency use is 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)	
		<b>Ambulance - Air:</b> 0% <a href="#">coinsurance</a>	<b>Ambulance - Air:</b> 0% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	0% <a href="#">coinsurance</a>	Not covered	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> may be required for certain services or benefits may be denied.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	Not covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	<b>Office:</b> 0% <a href="#">coinsurance</a> <b>Other:</b> 0% <a href="#">coinsurance</a>	<b>Office:</b> Not covered <b>Other:</b> Not covered	<a href="#">Preauthorization</a> may be required for certain services or benefits may be denied. Additional limitations and exclusions apply.
	Inpatient services	0% <a href="#">coinsurance</a>	Not covered	
<b>If you are pregnant</b>	Office visits	0% <a href="#">coinsurance</a>	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). <a href="#">Preauthorization</a> may be required for certain services or benefits may be denied.
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	Not covered	Limited to 30 Visits per calendar year. <a href="#">Preauthorization</a> is required, or services are not covered.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a>	Not covered	Limited to 20 Visits per calendar year total for rehabilitation and habilitation services. Benefits may be denied for failure to obtain <a href="#">preauthorization</a> for certain services.
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	Not covered	SNF and Acute Rehab Limited to 30 Days per calendar year each. Long Term Acute Care unlimited. <a href="#">Preauthorization</a> may be required for certain services.
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> may be required for certain services or benefits may be denied.
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	Not covered	Limited to 6 Months in every 3 years.

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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)	
				<a href="#">Preauthorization</a> is required or benefits may be denied.
<b>If your child needs dental or eye care</b>	Children's eye exam	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Limited to one routine eye exam per plan year.
	Children's glasses	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	One set of corrective lenses per year. Frames are not covered.
	Children's dental check-up	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 jii'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. 'ata sil 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](#) \$8,050
- [Specialist coinsurance](#) 0%
- [Hospital \(facility\) coinsurance](#) 0%
- [Other coinsurance](#) 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$7,500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$7,550</b>

**Managing Joe's type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$8,050
- [Specialist coinsurance](#) 0%
- [Hospital \(facility\) coinsurance](#) 0%
- [Other coinsurance](#) 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$5,300
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$5,320</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$8,050
- [Specialist coinsurance](#) 0%
- [Hospital \(facility\) coinsurance](#) 0%
- [Other coinsurance](#) 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>