



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: \$500/Individual, \$1,000/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 , \$150/individual or \$300/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: \$3,000/Individual, \$6,000/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	No Charge	Not covered	None.
	Specialist visit	\$50 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)	25% coinsurance	Not covered	Preauthorization may be required for certain services or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	25% 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: \$15 copay /Per Medication Deductible does not apply. Mail Order: \$30 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 Preauthorization may apply. Refer to the drug formulary for detailed information.
	Tier 2 (Non-Preferred Generic and Preferred Brand Drugs)	Retail: \$30 copay /Per Medication Deductible does not apply. Mail Order: \$60 copay /Per Medication Deductible does not apply.	Retail: Not covered Mail Order: Not covered	
	Tier 3 (Non-Preferred Brand Drugs)	Retail: 50% coinsurance Mail Order: Not covered	Retail: Not covered Mail Order: Not covered	
	Tier 4 (Specialty drugs)	Retail: 50% coinsurance Mail Order: Not covered	Retail: Not covered Mail Order: Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% 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	25% coinsurance	Not covered	Benefits may be denied for failure to obtain preauthorization for certain services.
If you need immediate medical attention	Emergency room care	\$250 copay /Per Visit	\$250 copay /Per Visit	Copay 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: \$250 copay /Per Visit Ambulance - Air: 25% coinsurance	Ambulance - Ground: \$250 copay /Per Visit Ambulance - Air: 25% coinsurance	Non-emergency use is not covered.
	Urgent care	No Charge	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	Preauthorization may be required for certain services or benefits may be denied.
	Physician/surgeon fees	25% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: No Charge Other: 25% 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	25% coinsurance	Not covered	
If you are pregnant	Office visits	25% 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). Preauthorization may be required for certain services or benefits may be denied.
	Childbirth/delivery professional services	25% coinsurance	Not covered	
	Childbirth/delivery facility services	25% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	Not covered	Limited to 30 Visits per calendar year. Preauthorization is required, or services are not covered.
	Rehabilitation services	25% coinsurance	Not covered	Limited to 20 Visits per calendar year total for rehabilitation and habilitation services. Benefits may be denied for failure to obtain preauthorization for certain services.
	Habilitation services	25% coinsurance	Not covered	

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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)	
	Skilled nursing care	25% 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	25% coinsurance	Not covered	Preauthorization may be required for certain services or benefits may be denied.
	Hospice services	25% coinsurance	Not covered	Limited to 6 Months in every 3 years. Preauthorization 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/>

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. '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](#) \$500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$2,700
<i>What isn't covered</i>	
Limits or exclusions	\$50
The total Peg would pay is	\$3,250

Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$600
Copayments	\$200
Coinsurance	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,520

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$900
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600