

 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: \$5,700/Individual, \$11,400/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? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | For In-Network Providers: \$7,200/Individual, \$14,400/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 | \$30 copay /Per Visit Deductible does not apply. | Not covered | None. |
| | Specialist visit | \$60 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) | 40% coinsurance | Not covered | Preauthorization may be required for certain services or benefits may be denied. |
| | Imaging (CT/PET scans, MRIs) | 40% 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: \$20 copay /Per Medication Deductible does not apply. Mail Order: \$40 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: \$40 copay /Per Medication Deductible does not apply. Mail Order: \$80 copay /Per Medication Deductible does not apply. | Retail: Not covered Mail Order: Not covered | |
| | Tier 3 (Non-Preferred Brand Drugs) | Retail: \$80 copay /Per Medication Mail Order: Not covered | Retail: Not covered Mail Order: Not covered | |
| | Tier 4 (Specialty drugs) | Retail: \$350 copay /Per Medication Mail Order: Not covered | Retail: Not covered Mail Order: 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) | |
| 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 | |
| If you need immediate medical attention | Emergency room care | 40% coinsurance | 40% coinsurance | 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: 40% coinsurance Ambulance - Air: 40% coinsurance | Ambulance - Ground: 40% coinsurance Ambulance - Air: 40% coinsurance | Non-emergency use is not covered. |
| | Urgent care | \$45 copay /Per Visit Deductible does not apply. | Not covered | None. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 40% coinsurance | Not covered | Preauthorization may be required for certain services or benefits may be denied. |
| | Physician/surgeon fees | 40% coinsurance | Not covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office: \$30 copay /Per Visit Deductible does not apply. Other: 40% 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 | 40% coinsurance | Not covered | |
| If you are pregnant | Office visits | 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). Preauthorization may be required for certain services or benefits may be denied. |
| | Childbirth/delivery professional services | 40% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 40% coinsurance | Not covered | |
| If you need help recovering or have other special health needs | Home health care | 40% coinsurance | Not covered | Limited to 30 Visits per calendar year. Preauthorization is required, or services are not covered. |
| | Rehabilitation services | \$30 copay /Per Visit Deductible does not apply. | Not covered | Limited to 20 Visits per calendar year total for rehabilitation and habilitation services. Benefits may be denied for |
| | Habilitation services | 40% 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) | |
| | | | | failure to obtain preauthorization for certain services. |
| | Skilled nursing care | 40% 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 | 40% coinsurance | Not covered | Preauthorization is required for durable medical equipment over \$1,000, or services are not covered. |
| | Hospice services | 40% 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 spēnīśa 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](#) \$5,700
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$5,700 |
| Copayments | \$0 |
| Coinsurance | \$1,500 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$50 |
| The total Peg would pay is | \$7,250 |

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

- The [plan's](#) overall [deductible](#) \$5,700
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$4,000 |
| Copayments | \$400 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$4,420 |

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

- The [plan's](#) overall [deductible](#) \$5,700
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,000 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,200 |