



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, visit <https://exchange.imperialhealthplan.com/utah/> or contact us at 1-800-595-0619 or <https://exchange.imperialhealthplan.com/utah/contact-information>. 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 <https://exchange.imperialhealthplan.com/utah/universal-glossary> or call 1-800-595-0619 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1000 per person \$2000 per group	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. Primary care, specialist visits, preventive care , generic drugs, preferred drugs, outpatient mental, behavioral, or substance abuse services, office visits while pregnant, child eye care, child dental care, are covered before meeting your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	\$8000 per person \$16000 per group	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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums , balance-billing charges, and health care this plan doesn't 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://www.imperialhealthplan.com/arizona/hmo-exchange/provider-directory or call 1-800-838-5914 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (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	\$20 copay /visit	Not covered	None
	Specialist visit	\$40 copay /visit	Not covered	
	Preventive care/screening/immunization	No Charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	35% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	35% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://client.formularynavigator.com/Search.aspx?siteCode=5261847175	Preventive drugs (Tier 1)	No Charge	Not Covered	Limited to 30 prescriptions per month. Preauthorization is required for certain drugs.
	Generic drugs (Tier 2)	\$5 copay /prescription	Not covered	
	Preferred brand drugs (Tier 3)	\$60 copay /prescription	Not covered	
	Non-preferred brand drugs (Tier 4)	50% coinsurance (retail & mail order)	Not covered	
	Specialty drugs (Tier 5)	50% coinsurance (retail & mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Not covered	Preauthorization is required.
	Physician/surgeon fees	35% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	35% coinsurance	35% coinsurance	None
	Emergency medical transportation	35% coinsurance	35% coinsurance	
	Urgent care	35% coinsurance	35% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance	Not covered	All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units; Preauthorization is required.
	Physician/surgeon fees	35% coinsurance	Not covered	

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://exchange.imperialhealthplan.com/utah/individual-eoc>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay /visit	Not covered	None
	Inpatient services	35% coinsurance	Not covered	
If you are pregnant	Office visits	\$20 copay /visit	Not covered	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	35% coinsurance	Not covered	
	Childbirth/delivery facility services	35% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	35% coinsurance	Not covered	30 visits per year.
	Rehabilitation services	35% coinsurance	Not covered	20 visits per year for each of the following: Chiropractic, Speech, Occupational, and Physical therapy.
	Habilitation services	35% coinsurance	Not covered	
	Skilled nursing care	35% coinsurance	Not covered	30 days per year.
	Durable medical equipment	35% coinsurance	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	35% coinsurance	Not covered	6 months per 3 years. Preauthorization and Medical Case Management required.
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Coverage limited to 1 exam/year.
	Children's glasses	No Charge	Not covered	Coverage limited to 1 pair of glasses/year.
	Children's dental check-up	No Charge	Not covered	Coverage limited to 2 dental check-ups & cleanings/calendar year.

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](#).)

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|--|--|--|
| • Abortion (except in cases of rape, incest, or when the life of the mother is endangered) | • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. |
| • Acupuncture | • Hearing aids | • Private-duty nursing |
| • Bariatric Surgery | • Infertility treatment (except diagnosis of the medical cause and surgery to treat medical cause) | • Routine eye care (Adult) |
| • Chiropractic care | • Long-term care | • Routine foot care |
| • Cosmetic Surgery | | • Weight loss programs |

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

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 are: Imperial Health Plan of the Southwest at 1-800-595-0619. You may also contact the Utah Department of Insurance at (800) 439-3805 at 4315 S. 2700 W., Suite 2300 Taylorsville, UT 84129 or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 on how 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: Utah Department of Insurance at (800) 439-3805 or visit <https://insurance.utah.gov>. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Utah Department of Insurance at (801) 957-9280.

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? Not Applicable.

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 (Español): Para obtener asistencia en Español, llame al 1-800-595-0619.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-595-0619.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-595-0619.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-800-595-0619.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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	\$1,000
■ Specialist coinsurance	\$40
■ Hospital (facility) coinsurance	35%
■ Other coinsurance	35%

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:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$30
Coinsurance	\$3,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,190

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,000
■ Specialist coinsurance	\$40
■ Hospital (facility) coinsurance	35%
■ Other coinsurance	35%

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:

Cost Sharing	
Deductibles	\$900
Copayments	\$1,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ Specialist coinsurance	\$40
■ Hospital (facility) coinsurance	35%
■ Other coinsurance	35%

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:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$300
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

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: 1-800-595-0619

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.