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 including your plan's Summary plan description, visit www.utpipetradesbenefits.org or call the Administrative Office at 1-877-416-8181. 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.dol.gov/ebsa/healthreform or call 1-877-416-8181 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers per calendar year: $450/individual. Out-of-Network Providers per calendar year: $900/individual.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and outpatient prescription drugs are covered before you meet 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. 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?	Medical Plan Network Providers: $4,000/individual; $8,000/family per calendar year. Out-of-Network Providers: Unlimited. Outpatient prescription drugs per calendar year: $2,600/individual; $5,200/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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	For the Medical Plan: Balance billing charges, health care this plan doesn't cover, outpatient retail/mail order drug expenses (which have a separate out-of-pocket limit), and out-of-network deductibles, copayments and coinsurance except an ER visit in cases of an emergency. The prescription drug out-of-pocket limit does not include premiums, balance-billing charges, medical plan expenses, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. Inside Utah see: www.wiseprovider.net or call 1-866-485-5205. Outside Utah see: www.myfirsthealth.com or call 1-888-685-7774.	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
		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	$35 copayment/visit plus 20% coinsurance.	$35 copayment/visit plus 40% coinsurance.	None.
	Specialist visit	$35 copayment/visit plus 20% coinsurance.	$35 copayment/visit plus 40% coinsurance.	Preauthorization of transplant services is required to avoid non-payment.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered.	Plan covers required preventive services and supplies described at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. Age and frequency guidelines apply to covered preventive care. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance.	40% coinsurance.	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance.	40% coinsurance.	Preauthorization of imaging tests is required to avoid non-payment.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at CVS Caremark at www.caremark.com or 1-877-819-9364.	Generic drugs	Retail Pharmacy for 30-day supply: $8 copayment per prescription; Mail Order for 90-day supply: $15 copayment per prescription. No charge for FDA-approved generic contraceptives.	If you fill a prescription at an Out-of-Network pharmacy, you pay 100% for the drug at the time of purchase and can file a claim with Caremark for reimbursement. The Plan reimburses no more than it would have paid had you used a Network pharmacy.	• Deductible does not apply. • Some prescriptions are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements. • Certain over-the-counter (OTC) and prescription drugs are payable at no charge with a prescription.
	Preferred brand drugs	Retail Pharmacy for 30-day supply: 30% coinsurance; Mail Order for 90-day supply: $45 copayment per prescription. No charge for FDA-approved brand name contraceptives if a generic is medically inappropriate.		
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: 50% coinsurance; Mail Order for 90-day supply: $60 copayment per prescription.		
	Specialty drugs	You pay 50% coinsurance up to $60 for up to a 30-day supply.		• Deductible does not apply. • Specialty drugs require preauthorization (to avoid non-payment) by calling CVS Caremark at 1-800-237-2767.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$35 copayment/visit plus 20% coinsurance.	$35 copayment/visit plus 40% coinsurance.	Preauthorization of outpatient surgery is required to avoid non-payment.
	Physician/ surgeon fees	20% coinsurance.	40% coinsurance.	Preauthorization of outpatient surgery is required to avoid non-payment.
If you need immediate medical attention	Emergency room care	$250 copayment/visit plus 20% coinsurance.	$250 copayment/visit plus 20% coinsurance.	Physician/provider's professional fees may be billed separately.
	Emergency medical transportation	20% coinsurance.	40% coinsurance.	None.
	Urgent care	$40 copayment/visit plus 20% coinsurance.	$40 copayment/visit plus 40% coinsurance.	None.

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 have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment/admission plus 20% coinsurance.	$500 copayment/admission plus 40% coinsurance.	Preauthorization of elective hospital admission is required to avoid non-payment.
	Physician/ surgeon fees	20% coinsurance.	40% coinsurance.	Preauthorization of elective hospital admission is required to avoid non-payment.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $35 copayment/visit plus 20% coinsurance. Other outpatient services: 20% coinsurance.	Office visits: $35 copayment/visit plus 40% coinsurance. Other outpatient services: 20% coinsurance.	Plan covers free short-term counseling visits through the EAP (Blomquist Hale) at 1-800-926-9619.
	Inpatient services	Hospital and Residential treatment facility: $250 copayment/visit plus 20% coinsurance.	Hospital: $500 copayment/visit plus 40% coinsurance. Residential treatment facility: Not covered.	Preauthorization of elective hospital admission and residential treatment program admission is required to avoid non-payment.
If you are pregnant	Office visits	No charge for office visits and ACA-required preventive services. Deductible does not apply. All other services for employee or spouse: 20% coinsurance.	For employee and spouse: 40% coinsurance.	• Cost sharing does not apply for preventive services. • Depending on the type of services, a copayment, coinsurance or deductible may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). • Prenatal care (other than ACA-required preventive screening) is not covered for dependent children.
	Childbirth delivery professional services	For employee and spouse: 20% coinsurance.	For employee and spouse: 40% coinsurance.	Preauthorization is required to avoid a financial penalty only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section. **Delivery expenses for a dependent child are not covered either in-network or out-of-network**.
	Childbirth delivery facility services	For employee and spouse: $250 copayment/visit plus 20% coinsurance.	For employee and spouse: $500 copayment/visit plus 40% coinsurance.	

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 help recovering or have other special health needs	Home health care	20% coinsurance.	40% coinsurance.	Part-time or intermittent skilled nursing care is covered.
	Rehabilitation services	Outpatient visits: 20% coinsurance. Inpatient Rehab. Admission: $250 copayment/visit plus 20% coinsurance.	Outpatient visits: 40% coinsurance. Inpatient Rehab. Admission: Not covered.	• Outpatient rehabilitation: physical, occupational & speech therapy maximum benefit is 60 days/calendar year. • Preauthorization of inpatient rehabilitation admission is required to avoid non-payment. • Maximum inpatient rehabilitation admission benefit is 60 days/calendar year when significant improvement can be obtained; additional therapy only if Physician certifies as medically necessary.
	Habilitation services	Not covered.	Not covered.	You must pay 100% of these expenses, even in-network.
	Skilled nursing care	$250 copayment/visit plus 20% coinsurance.	Not covered.	Preauthorization of skilled nursing facility admission is required to avoid non-payment. Maximum benefit is 60 days/calendar year. Must be in lieu of a hospital admission.
	Durable medical equipment	20% coinsurance.	40% coinsurance.	Rental of DME payable up to the allowed purchase price. Replacement covered once every 5 years. No charge from network providers for breastfeeding pump & supplies needed to operate.
	Hospice services	Home hospice: 20% coinsurance. Inpatient Hospice: $250 copayment/visit plus 20% coinsurance.	Home hospice: 40% coinsurance. Inpatient hospice: Not covered.	Covered if terminally ill. Preauthorization of inpatient hospice is required to avoid non-payment.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	You must pay 100% of these expenses, even in-network.
	Children's glasses	Not covered.	Not covered.	You must pay 100% of these expenses, even in-network.
	Children's dental check-up	Not covered.	Not covered.	You must pay 100% of these expenses, even in-network.

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.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult) • Habilitation services	• Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine eye care (Adult) • Weight loss programs (except as required by health reform law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery (once/lifetime)	• Chiropractic care (up to 30 visits/calendar year)	• Routine foot care payable when treating metabolic or peripheral vascular disease.

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 the Administrative Office/Medical Plan Claims Administrator (BeneSys) 1-877-416-8181, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes. If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 (Español): Para obtener asistencia en Español, llame al 1-877-416-8181.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-416-8181.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-416-8181.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-416-8181.

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 $450**
- **Specialist copayment +coinsurance $35 + 20%**
- **Hospital (facility) copayment + coinsurance $250 +20%**
- **Other coinsurance 20%**

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	**$12,800**

In this example, Peg would pay:

Cost sharing	
Deductibles	$450
Copayments	$480
Coinsurance	$1,970
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,910**

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

- **The plan's overall deductible $450**
- **Specialist copayment +coinsurance $35 +20%**
- **Hospital (facility) copayment + coinsurance $250 + 20%**
- **Other coinsurance 20%**

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	**$7,400**

In this example, Joe would pay:

Cost sharing	
Deductibles	$450
Copayments	$750
Coinsurance	$1,160
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,420**

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

- **The plan's overall deductible $450**
- **Specialist copayment +coinsurance $35 +20%**
- **Hospital (facility) ER copayment + coinsurance $250 + 20%**
- **Other coinsurance 20%**

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	**$1,900**

In this example, Mia would pay:

Cost sharing	
Deductibles	$450
Copayments	$390
Coinsurance	$220
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,060**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.