

UNIVERSITY OF UTAH  
EMPLOYEE HEALTH CARE PLAN

BASIC PLAN OPTION

SUMMARY OF MEDICAL BENEFITS

This section is an outline of how the Plan will pay medical benefits for those enrolled in the Basic Plan Option. See the Summary Plan Description included with this SUMMARY OF MEDICAL BENEFITS for all other terms of the Plan in detail. The Summary Plan Description includes a SUMMARY OF PRESCRIPTION DRUG BENEFITS and a SUMMARY OF BEHAVIORAL HEALTH BENEFITS for those enrolled in all Plan Options.

The Plan includes benefits for Network and Out-of-Network Providers. Your Health Plan Identification Card and the Summary Plan Description included with this SUMMARY OF MEDICAL BENEFITS indicates which panel of providers applies to Your benefits under the Plan.

NOTE: It is important to use Network Providers in order to receive the maximum benefits available under the Plan.

**Contract Year**

All Deductible, Maximum Coinsurance amounts and benefit limits, except those specified as Lifetime maximums, accumulate on a Contract Year basis, beginning July 1 and ending June 30.

**Maximum Benefit**

**For each Claimant Lifetime** **\$2,000,000**

The Maximum Benefit amount includes claims paid under all medical options of the University of Utah Employee Health Care Plan and Retiree Health Care Plan.

**Contract Year Deductible**

<b>Per Claimant</b>	<b>\$500</b>
<b>Per Family</b>	<b>3</b>

**Contract Year Maximum Coinsurance**

**Services provided by Network Providers:**

<b>Per Claimant</b>	<b>\$2,000</b>
<b>Per Family</b>	<b>3</b>

The Maximum Coinsurance can be met by payments of 30% Coinsurance for Network Provider services, but not by payments for non-covered services, Prescription Drugs purchased at a pharmacy (See the SUMMARY OF PRESCRIPTION DRUG BENEFITS Section for separate Prescription Drug Out-of-Pocket Maximum), Coinsurance for Behavioral Health services, Coinsurance for Out-of-Network Provider services, amounts charged by Out-of-Network Providers in excess of Eligible Medical Expenses, or any other payments made the Claimant. Coinsurance amounts that do not apply toward Maximum Coinsurance continue to be charged even after the Maximum Coinsurance has been reached.

**Services provided by Out-of-Network Providers:**

<b>Per Claimant</b>	<b>\$3,000</b>
<b>Per Family</b>	<b>2</b>

The Maximum Coinsurance can be met by payments of 30% and 50% Coinsurance for Out-of-Network Provider services, but not by payments for non-covered services, Prescription Drugs purchased at a pharmacy (See the SUMMARY OF PRESCRIPTION DRUG BENEFITS Section for separate Prescription Drug Out-of-Pocket Maximum), Coinsurance for Behavioral Health services, Coinsurance for Network Provider services, Deductible, or by any other payments made by the Claimant. Coinsurance amounts that do not apply toward Maximum Coinsurance continue to be charged even after the Maximum Coinsurance has been reached.

## **PERCENTAGE PLAN PAYS FOR COVERED SERVICES**

After any Deductible is satisfied, benefits are paid as follows:

### **Network Providers**

The Plan pays benefits for Covered Services of a Network Provider at the percentage listed. For Covered Services provided by a Network Provider, You pay only the Deductible and Coinsurance.

### **Out-of-Network Providers**

The Plan pays benefits for Covered Services of an Out-of-Network Provider at the percentage listed. For Covered Services provided by an Out-of-Network Provider, in addition to the Deductible and Coinsurance, *You pay the difference between billed charges and Eligible Medical Expenses (the "balance of billed charges")*.

NOTE: All payments for Covered Services as detailed in the following summary are based upon Eligible Medical Expenses, expressed as "EME." EME may differ based on the type of Provider rendering services and whether they are a Network Provider or an Out-of-Network Provider.

### **Ambulance Services**

	<b>Network Provider</b>	<b>Out-of-Network Provider</b>
Medically Necessary services to the nearest appropriate Hospital	After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 70% and You pay 30% of billed charges. 30% of billed charges will be applied toward Maximum Coinsurance.

### **Behavioral/Mental Health Services (Including Chemical Dependency)**

Behavioral Health Services are administered through Blomquist Hale Consulting and UNI BHN. See the SUMMARY OF BEHAVIORAL HEALTH BENEFITS and COVERED BEHAVIORAL HEALTH BENEFITS Sections in the Summary Plan Description for information on Behavioral Health Services.

### **Dental Care**

The Plan does not cover dental care except for the treatment of an Accidental Injury to sound natural teeth, in which case the coverage would be the same as any other Injury.

### **Durable Medical Equipment and Supplies, Prosthetic and Orthotic Devices**

	<b>Network Provider</b>	<b>Out-of-Network Provider</b>
Durable Medical Equipment and supplies, prosthetic and orthotic devices related directly to the treatment of an Illness or Injury	After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.

### **Emergency Department**

	<b>Network Provider</b>	<b>Out-of-Network Provider</b>
	After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 50% of EME and You pay the balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance <sup>1</sup> .

### **Hearing Services**

	<b>Network Provider</b>	<b>Out-of-Network Provider</b>
Services for the evaluation of hearing acuity <i>Limited to 1 visit per Claimant per Contract Year</i>	After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.

<sup>1</sup> For treatment of a qualifying Emergency Medical Condition (as defined in the Summary Plan Description) at an Out-of-Network Provider Emergency Room, the Plan pays 70% of billed charges and You pay 30% of billed charges. 30% of billed charges will be applied toward Maximum Coinsurance.

**Home Health Care and Home Infusion Therapy Services**

**Network Provider**  
 After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.

**Out-of-Network Provider**  
 After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.

**Hospice Care**

Specified services and supplies for a terminally ill Claimant

**Network Provider**  
 After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.

**Out-of-Network Provider**  
 After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.

**Hospital Inpatient Care**

Semiprivate room  
 Medical/surgical care  
 Intensive/coronary care unit  
 Medically Necessary Hospital services and supplies

**Network Provider**  
 After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.

**Out-of-Network Provider**  
 After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.

**Hospital Outpatient and Ambulatory Service Facility Care**

Outpatient surgery  
 Radiation and Chemotherapy  
 Preadmission Testing  
 Diagnostic x-ray and laboratory

**Network Provider**  
 After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.

**Out-of-Network Provider**  
 After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.

**Inpatient Rehabilitation Services**

Semiprivate room  
*Limited to 30 days per Claimant per Contract Year (refer to the Summary Plan Description for limits)*

**Network Provider**  
 After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.

**Out-of-Network Provider**  
 After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.

**Office or Clinic Care**

Office or clinic care for the treatment of an Illness or Injury

**Network Provider**  
 After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.

**Out-of-Network Provider**  
 After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.

**Outpatient Physiotherapy Services and Speech Therapy**

**Network Provider**  
 After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.

**Out-of-Network Provider**  
 After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.

**Prescription Drugs**

Prescription Drugs are administered through Caremark. See the SUMMARY OF PRESCRIPTION DRUG BENEFITS and COVERED PRESCRIPTION DRUG BENEFITS Sections in the Summary Plan Description for information on Prescription Drug coverage.

## Preventive Care Services

	Network Provider	Out-of-Network Provider
Services for children and adults, including specified immunizations <i>Limited to \$500 for one professional exam and one GYN exam (for females) per Claimant per Contract Year. Limits do not apply to preventive care for Claimants through age 5</i>	After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.
Screening Procedures (see Summary Plan Description for list) <i>Amounts paid are not included in the \$500 Limit above</i>	After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.

## Professional Provider Services and Maternity Care

	Network Provider	Out-of-Network Provider
Professional services in connection with inpatient and outpatient Hospital, emergency department and all other facility care	After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.

## Skilled Nursing Facility (SNF) Care

	Network Provider	Out-of-Network Provider
Semiprivate room Medically Necessary SNF services and supplies	After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.

## Vision Services

	Network Provider	Out-of-Network Provider
Specified services for the evaluation and treatment of visual acuity <i>Limited to 1 visit per Claimant per Contract Year</i>	After Deductible, Plan pays 70% of EME and You pay 30% of EME. 30% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.