# ARUP Laboratories, Inc.: PPO Medical 1500 Plan

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 1/1/2020-12/31/2020**

**Coverage for:** Large Group **Plan Type:** PPO

**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, contact University of Utah Health Insurance Plans at 1-833-981-0213. 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.uhealthplan.utah.edu/aruplabs or call 1-833-981-0213 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,500** Individual<br>**$3,000** Family of 2 or more<br><br>*Does not apply to preventive care or the first $1,000 of accidental injury expenses. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. **Copayments** are not applied to the deductible. |
| **Are there services covered before you meet your deductible?** | **Yes,** preventive services are not subject to your **deductible** when using an **in-network provider**. | Preventive services are covered at 100% when using an in-network provider. Check your policy or plan document for specific provider and prescription drug **copayments**. |
| **Are there other deductibles for specific services?** | **No** | 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?** | **$4,000** Individual<br>**$8,000** Family of 2 or more | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges and health care this plan doesn't cover. | Even though you pay for these expenses, they don't count toward the **out-of-pocket limit**. |
| **Will you pay less if you use a network provider?** | Yes. For a list of in-network providers visit www.uhealthplan.utah.edu/aruplabs or call 1-833-981-0213. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participation for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do you need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |

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: Network Provider (You will pay the least) | What You Will Pay: Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | ---None--- |
| | Specialist visit | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | ---None--- |
| | Preventive care/screening/ immunization | No Charge | 35% Coinsurance (After Deductible) | Refer to the plan document for a complete list of preventative services. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | ---None--- |
| | Imaging (CT/PET scans, MRIs) | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | ---None--- |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.navitus.com. | Tier 1 | **Retail PBM Network:** $5 1-30 day / $10 31-60 day / $15 61-90 day **Mail Order:** $5 1-30 day / $10 31-60 day / $12.50 61-90 day | Not Covered | Covers up to a 30-day supply, 90-day supply (mail order) for applicable copay. Eligible covered charges apply to out-of-pocket maximum. Certain compounded and preferred brand drugs are not covered under this plan. Contact the PBM for a list of excluded drugs. If a member or provider chooses a brand name drug when a generic is available, the member will be responsible for the appropriate copay plus the difference in cost between brand and generic. The difference in cost will not apply toward the Plan's Maximum Out-of-Pocket amount. However, if a provider recommends a particular contraceptive service or FDA-approved contraceptive item based on medical necessity for an individual, the Plan will cover the service or item at 100%. |
| | Tier 2 | **Retail PBM Network:** $30 1-30 day / $60 31-60 day / $90 61-90 day **Mail Order:** $30 1-30 day / $60 31-60 day / $75 61-90 day | Not Covered | |
| | Tier 3 | **Retail PBM Network:** 35% ($145 max) 1-30 day / 35% ($290 max) 31-60 day / 35% ($435 max) 61-90 day **Mail Order:** 35% ($145 max) 1-30 day / 35% ($290 max) 31-60 day / 35% ($375 max) 61-90 day | Not Covered | |
| | Specialty Medications | Tier 1: 35% $145 max (1-30 day) Tier 2: 35% $145 max (1-30 day) Tier 3: 35% $145 max (1-30 day) | Not Covered | Prior authorization required. Must use Navitus Rx Specialty Pharmacy. |

* For more information about limitations and exceptions, see the plan or policy document at www.uhealthplan.utah.edu/aruplabs.

| 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 outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | ---None--- |
| | Physician/surgeon fees | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | ---None--- |
| **If you need immediate medical attention** | Emergency room care | $250 copay + 15% after deductible | $250 copay + 15% after deductible | **Copayment** is waived if admitted directly to a hospital or facility on an inpatient basis. |
| | Emergency medical transportation | Deductible, then 15% Coinsurance | Deductible, then 15% Coinsurance | Non-emergency use is not covered. |
| | Urgent care | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | ---None--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | Prior authorization required. |
| | Physician/surgeon fees | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | ---None--- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | ---None--- |
| | Inpatient services | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | Prior authorization required. |
| **If you are pregnant** | Office visits | Covered at 100% | Deductible, then 35% Coinsurance | Prenatal care includes routine lab services, breastfeeding support/supplies/counseling, screening for gestational diabetes, and immunizations, as required under health care reform. Dependent daughters are covered. |
| | Childbirth/delivery professional services | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | ---None--- |
| | Childbirth/delivery facility services | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | ---None--- |
| **If you need help recovering or have other special health needs** | Home health care | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | No limit. Based on medical necessity. |
| | Rehabilitation services | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | No limit on inpatient or outpatient services. Based on medical necessity. |
| | Habilitation services | Deductible, then 15% Coinsurance | Deductible, then 35% 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) | |
| | | | | |
| | Skilled nursing care | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | No limit. Based on medical necessity. |
| | Durable medical equipment | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | Prior authorization required for charges over $5,000. |
| | Hospice services | Deductible, then 15% Coinsurance | Deductible, then 35% Coinsurance | Respite care is limited to 14 days per incident. |
| **If you need dental or eye care** | Eye exam | Covered at 100% | Deductible, then 35% Coinsurance | Limited to one routine eye exam per calendar year which includes retinal/diabetes, detailed examination and refraction. |
| | Glasses | Not Covered | Not Covered | Not Applicable |
| | Dental check-up | Not Covered | Not Covered | Not Applicable |

## 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.)**

- Abortions
- Private Duty Nursing
- Cosmetic Surgery
- Long-term Care
- Vision Care
- Infertility Services, except for diagnosis
- Dental Care
- Hearing Aids
- Exercise Programs
- Routine Foot Care

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

- Acupuncture
- Autism ABA Therapy
- Routine Eye Care
- Genetic Testing
- Elective Immunizations
- Chiropractic Services
- Diabetes Supplies
- Imaging Services
- Bariatric
- Phototherapy

**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: Office of the Superintendent of Insurance 1-801-538-3077. 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:

University of Utah Health Plans
Attention: Appeals Coordinator
P.O. Box 45180
Salt Lake City, UT 84145
Customer Service 1-833-981-0213

**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 1-833-981-0213.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-981-0213.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-833-981-0213.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-981-0213.

*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** **$1500**
- **Specialist Copayment** **15%**
- **Hospital (facility) Coinsurance** **15%**
- **Other Coinsurance** **15%**

**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 | $1,500 |
| Copayments | $20 |
| Coinsurance | $1890 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3470** |

### Managing Joe's type 2 Diabetes

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

- **The plan's overall deductible** **$1500**
- **Specialist Copay** **15%**
- **Hospital (facility) Coinsurance** **15%**
- **Other Coinsurance** **15%**

**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 | $1,500 |
| Copayments | $545 |
| Coinsurance | $439 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$2539** |

### Mia's Simple Fracture

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

- **The plan's overall deductible** **$1500**
- **Specialist Copayment** **15%**
- **Hospital (facility) Coinsurance** **15%**
- **Other Coinsurance** **15%**

**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 | $1,186 |
| Copayments | $750 |
| Coinsurance | $205 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,141** |

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