



University of Utah Health Insurance Plans  
 6053 Fashion Square Dr. Suite 110, Murray, Utah 84107

## COMPREHENSIVE MEDICAL COVERAGE

### OUTLINE OF COVERAGE – HEALTHY PREFERRED BRONZE HSA LIMITED

- **Read Your Policy Carefully** – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and University of Utah Health Plans (UUHP). It is, therefore, important that you READ YOUR POLICY CAREFULLY!
- **Comprehensive Medical Coverage** – This coverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy.
- **Notice** – This Plan does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. Coverage for pediatric dental services is available for purchase on a standalone basis through the Health Insurance Marketplace. Please contact the Health Insurance Marketplace to purchase the required pediatric dental services.

|   | SCHEDULE OF BENEFITS   |
|---|--|
| <b>HEALTHY PREFERRED BRONZE HSA LIMITED</b>                                   | <b>IN-NETWORK</b><br><i>You are responsible to pay the amounts shown below</i> |
| <b>CONDITIONS AND LIMITATIONS</b>   |  |
| <b>Lifetime Maximum Plan Payment</b>  | None   |
| <b>Pre-Existing Conditions</b>  | None   |
| <b>Benefit Accrual Period</b>   | Calendar Year  |
| <b>DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM</b>                                   | <b>IN-NETWORK</b>  |
| <b>Individual Deductible</b> – <i>Per person per calendar year</i>            | \$6,900  |
| <b>Family Deductible</b> – <i>Per family per calendar year</i>                | \$13,800   |
| <b>Individual Maximum Out-of-Pocket</b> – <i>Per person per calendar year</i> | \$6,900  |
| <b>Family Maximum Out-of-Pocket</b> – <i>Per family per calendar year</i>     | \$13,800   |

| INPATIENT SERVICES – <i>requires prior authorization</i>  | IN-NETWORK  |
|---|---|
| <b>Hospital</b> – <i>Medical/Surgical/Anesthesia</i><br><b>Physician</b> – <i>Medical/Surgical/Anesthesia</i><br><b>Mental Health or Substance Abuse Facility</b><br><b>Maternity Care</b><br><b>Skilled Nursing Facility</b> – <i>Up to 30 days per calendar year</i><br><b>Residential Treatment Facility/Partial Hospitalization</b> – <i>Up to 30 days/year</i><br><b>Hospice Care</b>  | 0% after deductible<br>0% after deductible<br>0% after deductible<br>0% after deductible<br>0% after deductible<br>0% after deductible<br>0% after deductible   |
| OUTPATIENT SERVICES   | IN-NETWORK  |
| <b>Office Visit</b><br>Preventive care/screenings/immunizations<br>Primary Care Provider (PCP)<br>Specialist<br>Mental Health or Substance Abuse<br><b>Urgent Care</b><br><b>Outpatient Surgery and Other Procedures</b><br><b>Medical Services Performed at an Outpatient Facility</b><br><b>Laboratory and Diagnostic Services</b><br><b>Imaging Services</b><br><b>Mental Health or Substance Abuse Therapy</b><br><b>Rehabilitation or Habilitation Therapy</b> – <i>Limited to 20 visits/year</i>  | Covered at 100%<br>0% after deductible<br>0% after deductible<br>0% after deductible<br>0% after deductible<br>0% after deductible<br>0% after deductible<br>0% after deductible<br>0% after deductible<br>0% after deductible<br>0% after deductible |
| EMERGENCY SERVICES  | IN-NETWORK  |
| <b>Emergency Room</b> – <i>Copay waived if admitted to the hospital</i><br><b>Ground Ambulance</b><br><b>Air Ambulance</b>  | 0% after deductible<br>0% after deductible<br>0% after deductible   |
| MISCELLANEOUS SERVICES  | IN-NETWORK  |
| <b>Durable Medical Equipment (DME)</b><br><b>Home Health Care</b> – <i>Up to 30 days per calendar year</i><br><b>In-Home Hospice Care</b><br><b>Medical Supplies</b><br><b>Dialysis Services</b><br><b>Eye exam</b> – <i>One visit per calendar year for adults and children</i><br><b>Glasses</b> – <i>One set of corrective lenses per year for children through age 18</i><br><i>*Frames are not covered</i>   | 0% after deductible<br>0% after deductible<br>0% after deductible<br>0% after deductible<br>0% after deductible<br>Covered at 100%<br>Covered at 100%   |
| PRESCRIPTION DRUG BENEFITS  | IN-NETWORK  |
| <b>Individual Deductible</b> – <i>Per person per calendar year</i><br><b>Family Deductible</b> – <i>Per family per calendar year</i><br><br><b>Prescription Drugs</b><br>Tier 1 – Preferred Generic Drugs<br>Tier 2 – Preferred Brand Drugs and Non-Preferred Generic Drugs – <i>may require prior authorization</i><br>Tier 3 – Non-Preferred Brand Drugs – <i>may require prior authorization</i><br>Tier 4 – Preferred Specialty Drugs – <i>requires prior authorization and must be filled at the University of Utah Specialty Pharmacy</i> | Included with Medical Deductible<br>Included with Medical Deductible<br><br>0% after deductible<br>0% after deductible<br><br>0% after deductible<br>0% after deductible  |

| OTHER BENEFITS             | WE PAY               |
|----------------------------|----------------------|
| Adoption Indemnity Benefit | \$4,000 Per Adoption |

\*Child must be placed for adoption within 30 days of the child's birth. If more than one newborn from a single pregnancy is adopted, only one adoption indemnity benefit is available.

## GENERAL LIMITATION AND EXCLUSIONS

- **Out-of-Network Charges** – You are responsible to pay for all charges on covered services obtained from Out-of-Network providers and facilities. These charges do not apply to your Maximum Out-of-Pocket.
- **Medical Necessity** – To qualify for benefits, covered services must be medically necessary. Medical necessity is determined by UUHP's Utilization Management team, which includes a medical director along with staff physicians.
- **Non-covered Services and Complications** – When a non-covered service is performed as part of the same operation or process as a covered service, only charges relating to the covered service will be considered. Allowed amounts may be calculated and fairly apportioned to exclude any charges related to the non-covered services.
- **Excluded Services** – Please see the Policy for a full list of excluded services.

## RENEWAL

This Policy is renewable at the option of the Policyholder upon payment of the monthly premium when due or within the grace period, except in cases of material fact or fraud in connection with the coverage, Our decision to cease offering this Policy to individual Policyholders, or Our decision to cease offering coverage in the individual market. Unless either formally terminated or otherwise renegotiated, the Policy will be renewed automatically on January 1 of each year. No modification or amendment will be effective until 30 days (or longer, as required by law) after written notice has been given to the Policyholder.

## PREMIUMS

Subject to the provisions of the Policy, the premiums will remain the same until the end of the term of the Policy, unless federal or state law or regulations mandate that UUHP modify benefits under the contract. Premiums are payable on the 1<sup>st</sup> day of each month.

The age categories for premiums are as follows: 0-20 years; each year from 21 to 64 years (your premium may change each year from age 21 to 64), and 65 years of age or older. If you or your dependent has a birthday that moves you/them into the next age category, rates may increase upon renewal.

