


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


**Coverage Period: 01/01/2020 – 12/31/2020**

**University of Utah Health Plans: Healthy Premier \$2800 QHDHP PPO**

**Coverage for: UUHP Level Funded 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 (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/lf-members](http://www.uhealthplan.utah.edu/lf-members) or call (833) 981-0213 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <b>in-network providers</b> : \$2,800 Per Person, \$5,600 Family For <b>out-of-network providers</b> : \$5,000 Per Person, \$10,000 Family	Generally, you must pay all the costs from <b>providers</b> up to the <b>deductible</b> amount before this plan begins to pay for covered services. Check your policy or plan document to see when the <b>deductible</b> starts over. See the chart starting on page 3 for how much you pay for covered services after you meet the <b>deductible</b> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes	This plan covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this <b>plan</b> covers certain <b>preventive services</b> without <b>cost sharing</b> and before you meet your <b>deductible</b> .
Are there other <a href="#">deductibles</a> for specific services?	No	You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <b>in-network providers</b> : \$5,000 Per Person, \$10,000 Family For <b>out-of-network providers</b> : \$10,000 Per Person, \$20,000 Family	The <b>out-of-pocket limit</b> 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 <a href="#">out-of-pocket limit</a> ?	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 <b>out-of-pocket limit</b> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of in-network providers visit <a href="http://www.uhealthplan.utah.edu">www.uhealthplan.utah.edu</a> or call 1-(833) 981-0213.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participation for <b>providers</b> in their <b>network</b> . See the chart starting on page 3 for how this plan pays different kinds of <b>providers</b> .
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <b>specialist</b> 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		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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	---None---
	<a href="#">Specialist</a> visit	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	---None---
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	Refer to the plan document for a complete list of preventative services.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	Preauthorization may be required for certain services.
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.uhealthplans.utah.edu">www.uhealthplans.utah.edu</a>	Preferred generic drugs 30 day supply 90 day supply -Mail order	Deductible, then 20% Coinsurance	Not Covered	Quantity Limits, Step Therapy, and Prior Authorization may apply. Refer to the drug formulary for detailed information.
	Preferred brand drugs 30 day supply 90 day supply -Mail order	Deductible, then 20% Coinsurance	Not Covered	
	Non-preferred brand drugs – 30 day supply 90 day supply -Mail order	Deductible, then 20% Coinsurance	Not Covered	
	Specialty drugs - <i>Must use University of Utah Specialty Pharmacy</i> – 30 day supply only	Deductible, then 20% Coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	Preauthorization may be required for certain services.
	Physician/surgeon fees	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	
If you need immediate medical attention	<a href="#">Emergency room care</a>	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance	<b>Copayment</b> is waived if admitted directly to a hospital or facility on an inpatient basis.
	<a href="#">Emergency medical transportation</a>	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance	Non-emergency use is not covered.
	<a href="#">Urgent care</a>	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	---None---

\* For more information about limitations and exceptions, see the plan or policy document at [www.uhealthplan.utah.edu/lf-members](http://www.uhealthplan.utah.edu/lf-members).

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)	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	Preauthorization may be required for certain services.
	Physician/surgeon fees	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	Preauthorization may be required for certain services.
	Inpatient services	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	
If you are pregnant	Office visits	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	Preauthorization may be required for certain services.
	Childbirth/delivery professional services	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	
	Childbirth/delivery facility services	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	Limited to 60 visits per year. <b><u>Prior authorization is required.</u></b>
	<a href="#">Rehabilitation services</a>	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	Limited to 40 visits per year total for both rehabilitation and habilitation services.
	<a href="#">Habilitation services</a>	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	Preauthorization may be required for certain services.
	<a href="#">Skilled nursing care</a>	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	Limited to 60 days per year. Preauthorization may be required for certain services.
	<a href="#">Durable medical equipment</a>	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	<b><u>Prior authorization is required</u></b> for durable medical equipment over \$5000.
	<a href="#">Hospice services</a>	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance	<b><u>Prior authorization is required.</u></b>
If you need dental or eye care	Eye exam	No Charge	Not Covered	Limited to one routine eye exam per plan year.
	Glasses	Not Covered	Not Covered	Not Applicable
	Dental check-up	Not Covered	Not Covered	Not Applicable

\* For more information about limitations and exceptions, see the plan or policy document at [www.uhealthplan.utah.edu/lf-members](http://www.uhealthplan.utah.edu/lf-members).

### 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](#).)

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric Surgery</li><li>• Private Duty Nursing</li></ul> | <ul style="list-style-type: none"><li>• Cosmetic Surgery</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Dental Care</li><li>• Hearing aids</li><li>• Weight loss programs</li></ul> |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"><li>• Adoption Services</li></ul> | <ul style="list-style-type: none"><li>• Mastectomy and Breast Reconstruction</li></ul> | <ul style="list-style-type: none"><li>• ABA Therapy for Autism</li></ul> |
|---|--|--|

**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](http://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 (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 (833) 981-0213.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (833) 981-0213.

Chinese (中文): 如果需要中文的帮助, ☎☎打☎个号(833) 981-0213.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (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](#) **\$2800**
- [Specialist](#) Copayment **20%**
- Hospital (facility) Coinsurance **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*)

<b>Total Example Cost</b>	<b>\$7,500</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2800
Copayments	\$0
Coinsurance	\$2300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7671</b>

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

- The [plan's](#) overall [deductible](#) **\$2800**
- [Specialist](#) Copay **20%**
- Hospital (facility) Coinsurance **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*)

<b>Total Example Cost</b>	<b>\$5,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2800
Copayments	\$0
Coinsurance	\$1437
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$4192</b>

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

- The [plan's](#) overall [deductible](#) **\$2800**
- [Specialist](#) Copayment **20%**
- Hospital (facility) Coinsurance **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*)

<b>Total Example Cost</b>	<b>\$4780</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1540
Copayments	\$0
Coinsurance	\$385
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1925</b>