UNIVERSITY OF UTAH
EMPLOYEE HEALTH CARE PLAN

COMPREHENSIVE PLAN OPTION

SUMMARY OF MEDICAL BENEFITS

This section is an outline of how the Plan will pay medical benefits for those enrolled in the Comprehensive 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 indicate 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 and ERIP Health Care Plans.

Contract Year Deductible

Per Claimant	**$250**
Per Family	**3**

Contract Year Maximum Coinsurance

Per Claimant	**$1,500**
Per Family	**3**

The Maximum Coinsurance can be met by payments of 20% Coinsurance, but not by payments for Prescription Drugs purchased at a pharmacy (see SUMMARY OF PRESCRIPTION DRUG BENEFITS for separate Prescription Drug Out-of-Pocket Maximum), non-covered services, Behavioral Health services, Deductible, amounts charged by Out-of-Network Providers in excess of Eligible Medical Expenses, or 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

	Network Provider	Out-of-Network Provider
Medically Necessary services to the nearest appropriate Hospital	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% and You pay 20% of billed charges. 20% of billed charges will be applied toward Maximum Coinsurance.

Behavioral Health Services

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

	Network Provider	Out-of-Network Provider
Durable Medical Equipment and supplies, prosthetic and orthotic devices related directly to the treatment of an Illness or Injury	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Employee Assistance Program (EAP)

The Plan offers access to short-term, solution-focused counseling through Blomquist Hale Consulting. See SUMMARY OF BEHAVIORAL HEALTH BENEFITS Section in the Summary Plan Description for detailed information on the EAP benefit.

Emergency Department		
	Network Provider	Out-of-Network Provider
	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay the balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance[1].

Hearing Services		
	Network Provider	Out-of-Network Provider
Services for the evaluation of hearing acuity *Limited to 1 visit per Claimant per Contract Year*	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Home Health Care		
	Network Provider	Out-of-Network Provider
	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Home Infusion Therapy Services		
	Network Provider	Out-of-Network Provider
	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Hospice Care		
	Network Provider	Out-of-Network Provider
Specified services and supplies for a terminally ill Claimant	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

[1] 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 80% of billed charges and You pay 20% of billed charges. 20% of billed charges will be applied toward Maximum Coinsurance.

Hospital Inpatient Care

	Network Provider	Out-of-Network Provider
Semiprivate room Medical/surgical care Intensive/coronary care unit Medically Necessary Hospital services and supplies	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Hospital Outpatient and Ambulatory Service Facility Care

	Network Provider	Out-of-Network Provider
Outpatient surgery Radiation and Chemotherapy Preadmission Testing Diagnostic x-ray and laboratory	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Inpatient Rehabilitation Services

	Network Provider	Out-of-Network Provider
Semiprivate room *Limited to 30 days per Claimant per Contract Year (this limit may be increased when approved in advance by the Claims Administrator for certain conditions such as a head or spinal cord Injury, or for treatment of a stroke to a maximum of 60 days per Claimant per Contract Year)*	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Maternity Care

	Network Provider	Out-of-Network Provider
Covered Services include Physician's obstetrical care and other Provider services and supplies related to pregnancy or any complications of pregnancy, including prenatal, delivery and postnatal care	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Mental Health Services (Including Chemical Dependency)

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

Office or Clinic Care

	Network Provider	Out-of-Network Provider
Office or clinic care for the treatment of an Illness or Injury	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Outpatient Physiotherapy Services

	Network Provider	Out-of-Network Provider
	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Prescription Drugs

Prescription Drugs are administered through CVS 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 *Limited to $500 for one professional exam, one GYN exam (for females), and routine diagnostic tests per Claimant over age 5 per Contract Year. Limit does not apply to immunizations or Preventive Care Services for Claimants through age 5.*	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.
Screening Procedures (see Summary Plan Description for list) *Amounts paid are not included in the $500 Limit above*	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Professional Provider Services

	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 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% 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 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Speech Therapy Services

	Network Provider	Out-of-Network Provider
For Claimants through age 12, limited to $1,500 per Claimant per Contract Year for services to restore or improve speech function resulting from congenital anomalies. (Limit does not apply to other covered Speech Therapy Services.)	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Transplants

The Plan covers Medically Necessary services provided in connection with those transplants that are listed as a Covered Service the same as any other Illness or Injury.

Vision Services

	Network Provider	Out-of-Network Provider
Routine vision examination *Limited to 1 visit per Claimant per Contract Year*	After Deductible, Plan pays 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.