University of Utah Advantage Plan

Coverage Period: 07/01/2016 – 06/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual & Eligible Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.Regence.com or by calling 1 (800) 262-9712.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network **$0** claimant per plan year. Out-of-network: **$350** claimant / **$700** family per plan year.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use with an out-of-network provider. The **deductible** starts over (usually, but not always, July 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$200** for each inpatient admission for behavioral health benefits or **$300** for each chemical dependency course of treatment not coordinated through the EAP. There are no other specific **deductibles**.	In the event you do not obtain a referral from the EAP, 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.
Is there an out-of-pocket limit on my expenses?	Yes. **$2,000** claimant / **$5,000** family per plan year for medical expenses; **$2,000** claimant / **$4,000** family per plan year for prescription medication expenses; and **$2,000** claimant / **$4,000** family per plan year for behavioral health and chemical dependency expenses.	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 these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See **www.Regence.com** or call **1 (800) 262-9712** for lists of **preferred** or participating **providers**.	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 participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1 (800) 262-9712 or visit us at www.Regence.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.cciio.cms.gov or call 1 (800) 262-9712 to request a copy.

Claims Administrator: Regence BlueCross BlueShield of Utah
UU0116SPRFX

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out–of–network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out–of–network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred** and participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a University Health Care Provider	Your Cost If You Use a Preferred or Participating Provider	Your Cost If You Use a Non-participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay / visit	$30 copay / visit	Deductible, 35% of allowed amount, and balance billing	**Copayment** applies to each preferred office visit only. All other services are covered at the **co-insurance** specified.
	Specialist visit	$5 copay / visit	$30 copay / visit	Deductible, 35% of allowed amount, and balance billing	
	Other practitioner office visit	$5 copay / office visit for spinal manipulations	$30 copay / office visit for spinal manipulations	Deductible, 35% of allowed amount, and balance billing	Coverage is limited to 20 spinal manipulations / year.
	Preventive care/ screening/immunization	No charge	No charge	Deductible, 35% of allowed amount, and balance billing	————————none————————
If you have a test	Diagnostic test (x–ray, blood work)	No charge	20% coinsurance	Deductible, 35% of allowed amount, and balance billing	————————none————————
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Deductible, 35% of allowed amount, and balance billing	

Common Medical Event	Services You May Need	Your Cost If You Use a University Health Care Provider	Your Cost If You Use a Preferred or Participating Provider	Your Cost If You Use a Non-participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Regence.com	Generic drugs	20% coinsurance (not to exceed $150) / retail and self-administrable cancer chemotherapy prescription	25% coinsurance (not to exceed $150) / retail and self-administrable cancer chemotherapy prescriptions	25% coinsurance (not to exceed $150) / retail and self-administrable cancer chemotherapy prescriptions	**Out–of–pocket limit**: $150 per prescription / 30-day fill, $2,000 claimant / $4,000 family / year. Coverage is limited to a 90-day supply retail and mail order. Medications used as part of an outpatient cancer drug treatment regimen that is provided and dispensed in a professional setting will be subject to these prescription benefits. You are responsible for the difference in cost between a dispensed brand–name drug and the equivalent generic drug, in addition to the **copayment** and/or **coinsurance**, unless your **provider** specifies "dispense as written."
	Preferred brand drugs	20% coinsurance (not to exceed $150) / retail and self-administrable cancer chemotherapy prescription	25% coinsurance (not to exceed $150) / retail and self-administrable cancer chemotherapy prescriptions	25% coinsurance (not to exceed $150) / retail and self-administrable cancer chemotherapy prescriptions	
	Non–preferred brand drugs	20% coinsurance (not to exceed $150) / retail and self-administrable cancer chemotherapy prescription	35% coinsurance (not to exceed $150) / retail and self-administrable cancer chemotherapy prescriptions	35% coinsurance (not to exceed $150) / retail and self-administrable cancer chemotherapy prescriptions	
	Specialty drugs	Refer to generic, preferred brand and non–preferred brand drugs above.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Deductible, 35% of allowed amount, and balance billing	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a University Health Care Provider	Your Cost If You Use a Preferred or Participating Provider	Your Cost If You Use a Non-participating Provider	Limitations & Exceptions
	Physician/surgeon fees	No charge	20% coinsurance	Deductible, 35% of allowed amount, and balance billing	——————none——————
If you need immediate medical attention	Emergency room services	$150 copay / visit	$150 copay / visit	$150 copay / visit	**Copayment** applies to the facility charge for each visit (waived if admitted).
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	Covered the same as the **If you visit a health care provider's office or clinic** or **If you have a test** Common Medical Events.			——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Deductible, 35% of allowed amount, and balance billing	——————none——————
	Physician/surgeon fee	No charge	20% coinsurance	Deductible, 35% of allowed amount, and balance billing	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a University Health Care Provider	Your Cost If You Use a Preferred or Participating Provider	Your Cost If You Use a Non-participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	With EAP referral: $25 copay / visit Without EAP referral: 50% coinsurance			**Deductible** waived for inpatient and outpatient services with an EAP referral. **Deductible** waived for outpatient services without an EAP referral. Coverage is limited to 20 outpatient visits / year for mental health services. Coverage is limited to 30 inpatient days / year for mental health services. Coverage is limited to 2 courses of treatment / lifetime for substance use disorder services. Mental health, behavioral or substance abuse benefits are administered by Blomquist Hale Consulting Employee Assistance Program and UNI BHN, not Regence BlueCross BlueShield of Utah. Contact Blomquist Hale Consulting EAP or UNI BHN at (801) 587-9319, (801) 262-9619 or (800) 926-9619.
	Mental/Behavioral health inpatient services	With EAP referral: 20% coinsurance Without EAP referral: 50% coinsurance			
	Substance use disorder outpatient services	With EAP referral: 20% coinsurance Without EAP referral: 50% coinsurance			
	Substance use disorder inpatient services	With EAP referral: 20% coinsurance Without EAP referral: 50% coinsurance			
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	Deductible, 35% of allowed amount, and balance billing	Coverage for adoption expenses is limited to $4,000 / pregnancy. The adoption indemnity benefit is not exchangeable for infertility treatment benefits.
	Delivery and all inpatient services	No charge	20% coinsurance	Deductible, 35% of allowed amount, and balance billing	

Common Medical Event	Services You May Need	Your Cost If You Use a University Health Care Provider	Your Cost If You Use a Preferred or Participating Provider	Your Cost If You Use a Non-participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Deductible, 35% of allowed amount, and balance billing	——————none——————
	Rehabilitation services	No charge	20% coinsurance	Deductible, 35% of allowed amount, and balance billing	Coverage is limited to 30 inpatient days / year.
	Habilitation services	No charge	20% coinsurance	Deductible, 35% of allowed amount, and balance billing	Coverage for neurodevelopmental therapy limited to services for claimants through age 18. Coverage is limited to $1,500 / year (combined with speech therapy resulting from congenital anomaly, for claimants age 18 and under).
	Skilled nursing care	No charge	20% coinsurance	Deductible, 35% of allowed amount, and balance billing	——————none——————
	Durable medical equipment	No charge	20% coinsurance	Deductible, 35% of allowed amount, and balance billing	——————none——————
	Hospice service	No charge	20% coinsurance	Deductible, 35% of allowed amount, and balance billing	Coverage is limited to 14 respite days / lifetime.
If your child needs dental or eye care	Eye exam	$5 copay / visit	$30 copay / visit	Deductible, 35% of allowed amount, and balance billing	Coverage is limited to 1 routine eye exam / year.
	Glasses	Not covered	Not covered	Not covered	——————none——————
	Dental check–up	Not covered	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Exclusion Examples

The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under your plan, including related secondary medical conditions and are not inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
  - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
  - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- complications that result from an injury or illness resulting from active participation in illegal activities.

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Vision hardware
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Applied behavioral analysis (ABA) therapy
- Bariatric surgery
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1 (800) 262-9712. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444–3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1 (877) 267–2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1 (800) 262-9712 or visit www.Regence.com. You may also contact your state insurance department at 1 (800) 439-3805 or www.insurance.utah.gov or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444–3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides**.

Language Access Services:

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1 (800) 262-9712.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays $6,080**
- **Patient pays $1,460**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co–pays	$0
Co–insurance	$1,460
Limits or exclusions	$0
Total	**$1,460**

Managing type 2 diabetes
(routine maintenance of a well–controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays $4,300**
- **Patient pays $1,100**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co–pays	$180
Co–insurance	$920
Limits or exclusions	$0
Total	**$1,100**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out–of–pocket expenses are based only on treating the condition in the example.
- The patient received all care from in–network **providers**. If the patient had received care from out–of–network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out–of–pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out–of–pocket expenses.