ARUP Laboratories, Inc.: EPO Medical 750 Plan

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

Coverage Period: 1/1/2019-12/31/2020

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

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 1-888-271-5870. 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 1-888-271-5870 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$750** Individual **$1,500** Family of 2 or more *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 **$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, out-of-network charges, 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 1-888-271-5870.	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		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 provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then 15% Coinsurance	Not Covered	---None---
	Specialist visit	Deductible, then 15% Coinsurance	Not Covered	---None---
	Preventive care/screening/ immunization	No Charge	Not Covered	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	Not Covered	---None---
	Imaging (CT/PET scans, MRIs)	Deductible, then 15% Coinsurance	Not Covered	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com.	Generic drugs	Navitus Limited Network / 30 Day Mail Order: $5 copay 90 Day Mail Order: $12.50 copay	Not Covered	Covers up to a 30-day supply (mail order), 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%.
	Formulary brand drugs	Navitus Limited Network / 30 Day Mail Order: $30 copay 90 Day Mail Order: $75 copay	Not Covered	
	Non-formulary brand drugs/ Non-formulary Specialty drugs/ Injectables	Navitus Limited Network / 30 Day Mail Order: 35% up to $145 90 Day Mail Order: 35% up to $362.50	Not Covered	
	Specialty Medications	Navitus Limited Network: 35% up to $150 (Lumceira)	Not Covered	Prior authorization required. Must use or Navitus 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	Not Covered	---None---
	Physician/surgeon fees	Deductible, then 15% Coinsurance	Not Covered	---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	Not Covered (inside the coverage area); 15% after deductible (outside the coverage area)	Must see a contracted urgent care provider within the coverage area. Urgent care providers outside of Salt Lake, Davis, Weber and Utah counties will be covered at the In-Network benefit level.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 15% Coinsurance	Not Covered	Prior authorization required.
	Physician/surgeon fees	Deductible, then 15% Coinsurance	Not Covered	---None---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible, then 15% Coinsurance	Not Covered	---None---
	Inpatient services	Deductible, then 15% Coinsurance	Not Covered	Prior authorization required.
If you are pregnant	Office visits	Covered at 100%	Not Covered	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	Not Covered	---None---
	Childbirth/delivery facility services	Deductible, then 15% Coinsurance	Not Covered	---None---
If you need help recovering or have other special health needs	Home health care	Deductible, then 15% Coinsurance	Not Covered	No limit. Based on medical necessity.
	Rehabilitation services	Deductible, then 15% Coinsurance	Not Covered	

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)	
	Habilitation services	Deductible, then 15% Coinsurance	Not Covered	No limit on inpatient and outpatient services. Neurodevelopmental therapy is limited to 40 outpatient visits per year for dependent children through age 6 only.
	Skilled nursing care	Deductible, then 15% Coinsurance	Not Covered	No limit. Based on medical necessity.
	Durable medical equipment	Deductible, then 15% Coinsurance	Not Covered	Prior authorization required for charges over $1,500.
	Hospice services	Deductible, then 15% Coinsurance	Not Covered	Respite care is limited to 14 days per lifetime.
If you need dental or eye care	Eye exam	Covered at 100%	Not Covered	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 Surgery
- Phototherapy

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

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 1-888-271-5870

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 1-888-271-5870.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-271-5870.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-888-271-5870.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-271-5870.

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** **$750**
- **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	**$7540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$20
Coinsurance	$1890
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2720**

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

- **The plan's overall deductible** **$750**
- **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	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$545
Coinsurance	$439
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1789**

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

- **The plan's overall deductible** **$750**
- **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	**$4780**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$750
Coinsurance	$205
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,705**

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