

# ARUP Laboratories, Inc.: PPO Medical 1500 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: 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 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](http://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 <a href="#">deductible</a> ?	<p><b>\$1,500</b> Individual  <b>\$3,000</b> Family of 2 or more</p> <p>*Does not apply to preventive care or the first \$1,000 of accidental injury expenses.</p>	You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> starts over. See the chart starting on page 2 for how much you pay for covered services after you meet the <b><u>deductible</u></b> . <b><u>Copayments</u></b> are not applied to the deductible.
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Yes</b> , preventive services are not subject to your <b><u>deductible</u></b> when using an <b><u>in-network provider</u></b> .	Preventive services are covered at 100% when using an in-network provider. Check your policy or plan document for specific provider and prescription drug <b><u>copayments</u></b> .
Are there other <a href="#">deductibles</a> for specific services?	<b>No</b>	You must pay all of the costs for these services up to the specific <b><u>deductible</u></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> ?	<p><b>\$4,000</b> Individual  <b>\$8,000</b> Family of 2 or more</p>	The <b><u>out-of-pocket limit</u></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><u>out-of-pocket limit</u></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/aruplabs">www.uhealthplan.utah.edu/aruplabs</a> or call 1-888-271-5870.	If you use an in-network doctor or other health care <b><u>provider</u></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><u>provider</u></b> for some services. Plans use the term in-network, <b><u>preferred</u></b> , or participation for <b><u>providers</u></b> in their <b><u>network</u></b> . See the chart starting on page 2 for how this plan pays different kinds of <b><u>providers</u></b> .
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <b><u>specialist</u></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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	---None---
	<a href="#">Specialist</a> visit	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	---None---
	<a href="#">Preventive care/screening/immunization</a>	No Charge	35% Coinsurance (Deductible waived)	Refer to the plan document for a complete list of preventative services.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	---None---
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.navitus.com">www.navitus.com</a> .	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, 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	

\* For more information about limitations and exceptions, see the plan or policy document at [www.uhealthplan.utah.edu/aruplabs](http://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	Deductible, then 35% Coinsurance	---None---
	Physician/surgeon fees	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	---None---
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 copay + 15% after deductible	\$250 copay + 15% after deductible	<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 15% Coinsurance	Deductible, then 15% Coinsurance	Non-emergency use is not covered.
	<a href="#">Urgent care</a>	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	Prior authorization required.
	Physician/surgeon fees	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	---None---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	---None---
	Inpatient services	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	Prior authorization required.
If you are pregnant	Office visits	Covered at 100%	Deductible, then 35% Coinsurance	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	Deductible, then 35% Coinsurance	---None---
	Childbirth/delivery facility services	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	---None---
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	No limit. Based on medical necessity.
	<a href="#">Rehabilitation services</a>	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	No limit on inpatient or outpatient services. Based on medical necessity.
	<a href="#">Habilitation services</a>	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	

\* For more information about limitations and exceptions, see the plan or policy document at [www.uhealthplan.utah.edu/aruplabs](http://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)	
				Neurodevelopmental therapy is limited to 40 outpatient visits per year for dependent children through age 6 only.
	<a href="#">Skilled nursing care</a>	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	No limit. Based on medical necessity.
	<a href="#">Durable medical equipment</a>	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	Prior authorization required for charges over \$1,500.
	<a href="#">Hospice services</a>	Deductible, then 15% Coinsurance	Deductible, then 35% Coinsurance	Respite care is limited to 14 days per lifetime.
<b>If you need dental or eye care</b>	Eye exam	Covered at 100%	Deductible, then 35% Coinsurance	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>• Abortions</li> <li>• Private Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Long-term Care</li> <li>• Vision Care</li> <li>• Infertility Services, except for diagnosis</li> </ul>	<ul style="list-style-type: none"> <li>• Dental Care</li> <li>• Hearing Aids</li> <li>• Exercise Programs</li> <li>• Routine Foot Care</li> </ul>	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)			
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Autism ABA Therapy</li> <li>• Routine Eye Care</li> </ul>	<ul style="list-style-type: none"> <li>• Genetic Testing</li> <li>• Elective Immunizations</li> <li>• Chiropractic Services</li> </ul>	<ul style="list-style-type: none"> <li>• Diabetes Supplies</li> <li>• Imaging Services</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric</li> <li>• Phototherapy</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:

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

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, kwijigo holne' 1-888-271-5870.

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*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1500
■ <a href="#">Specialist</a> 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*)

<b>Total Example Cost</b>	<b>\$7,540</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$20
Coinsurance	\$1890
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3470</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1500
■ <a href="#">Specialist</a> 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*)

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

Cost Sharing	
Deductibles	\$1,500
Copayments	\$545
Coinsurance	\$439
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2539</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1500
■ <a href="#">Specialist</a> 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*)

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

Cost Sharing	
Deductibles	\$1,186
Copayments	\$750
Coinsurance	\$205
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,141</b>