

UNIVERSITY OF UTAH
EMPLOYEE HEALTH CARE PLAN

ADVANTAGE PLAN OPTION

SUMMARY OF MEDICAL BENEFITS

This section is an outline of how the Plan will pay medical benefits for those enrolled in the Advantage 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 indicates 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 Health Care Plan.

Contract Year Deductible

Services provided by Network Providers:
Per Claimant **\$0**

Services provided by Out-of-Network Providers:
Per Claimant **\$250**
Per Family **3**

Contract Year Maximum Coinsurance

Services provided by Network Providers:
Per Claimant **\$1,500**
Per Family **3**

The Maximum Coinsurance can be met by payments of 10% Coinsurance for Network Provider services, but not by payments for non-covered services, Copayments, Prescription Drugs purchased at a pharmacy (See the SUMMARY OF PRESCRIPTION DRUG BENEFITS Section for separate Prescription Drug Out-of-Pocket Maximum), Coinsurance/Copayments for Behavioral Health services, Coinsurance for Out-of-Network Provider services, amounts charged by Out-of-Network Providers in excess of Eligible Medical Expenses, or any other payments made the Claimant. Coinsurance amounts that do not apply toward Maximum Coinsurance continue to be charged even after the Maximum Coinsurance has been reached.

Services provided by Out-of-Network Providers:
Per Claimant **\$3,000**
Per Family **2**

The Maximum Coinsurance can be met by payments of 35% Coinsurance for Out-of-Network Provider services, but not by payments for non-covered services, Prescription Drugs purchased at a pharmacy (See the SUMMARY OF PRESCRIPTION

DRUG BENEFITS Section for separate Prescription Drug Out-of-Pocket Maximum), Coinsurance for Behavioral Health services, Coinsurance for Network Provider services, Deductible, or by 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.

AMOUNT PLAN PAYS FOR COVERED SERVICES

Copayments

You are responsible to pay the following Copayment amounts:

\$75 per visit to a Hospital emergency department for an Emergency Medical Condition. This Copayment is waived when admitted for an emergency/urgent medical condition and the applicable Coinsurance amount applies.

\$20 per visit to a Network Physician's or Practitioner's office or clinic or for each house visit made by a Network Physician or Practitioner.

Coinsurance

For Covered Services for which a Copayment is not required, 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 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	Plan pays 90% of EME and You pay 10% of EME. 10% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 90% and You pay 10% of billed charges. 10% of billed charges will be applied toward Maximum Coinsurance.

Behavioral/Mental Health Services (Including Chemical Dependency)

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	Plan pays 90% of EME and You pay 10% of EME. 10% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 65% of EME and You pay balance of billed charges. 35% of EME will be applied toward Maximum Coinsurance.

Emergency Department

Network Provider

You pay \$75 Copayment per visit. After Copayment, Plan pays 100% of EME.

Out-of-Network Provider

After Deductible, Plan pays 65% of EME and You pay the balance of billed charges. 35% of EME will be applied toward Maximum Coinsurance¹.

Home Health Care

Network Provider

You pay \$20 Copayment per visit. After Copayment, Plan pays 100% of EME.

Out-of-Network Provider

After Deductible, Plan pays 65% of EME and You pay balance of billed charges. 35% of EME will be applied toward Maximum Coinsurance.

Home Infusion Therapy Services and Hospice Care

Network Provider

Plan pays 90% of EME and You pay 10% of EME. 10% of EME will be applied toward Maximum Coinsurance.

Out-of-Network Provider

After Deductible, Plan pays 65% of EME and You pay balance of billed charges. 35% of EME will be applied toward Maximum Coinsurance.

Hospital Inpatient Care

Semiprivate room
Medical/surgical care
Intensive/coronary care unit
Medically Necessary Hospital services and supplies

Network Provider

University of Utah Hospitals: Plan pays 100% of EME.
All other Network Hospitals: Plan pays 90% of EME and You pay 10% of EME. 10% of EME will be applied toward Maximum Coinsurance.

Out-of-Network Provider

After Deductible, Plan pays 65% of EME and You pay balance of billed charges. 35% of EME will be applied toward Maximum Coinsurance.

Hospital Outpatient and Ambulatory Service Facility Care

Outpatient surgery
Radiation and Chemotherapy
Preadmission Testing
Diagnostic x-ray and laboratory

Network Provider

Plan pays 90% of EME and You pay 10% of EME. 10% of EME will be applied toward Maximum Coinsurance.

Out-of-Network Provider

After Deductible, Plan pays 65% of EME and You pay balance of billed charges. 35% 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, You pay \$75 Copayment per visit; after Copayment the Plan pays 100% of billed charges. No amounts will be applied toward Maximum Coinsurance.

Inpatient Rehabilitation Services

	Network Provider	Out-of-Network Provider
Semiprivate room <i>Limited to 30 days per Claimant per Contract Year (refer to the Summary Plan Description for limits)</i>	Plan pays 90% of EME and You pay 10% of EME. 10% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 65% of EME and You pay balance of billed charges. 35% of EME will be applied toward Maximum Coinsurance.

Office or Clinic Care, Hearing and Vision Services

	Network Provider	Out-of-Network Provider
Office or clinic care for the treatment of an Illness or Injury <i>Hearing and Vision Services Limited to 1 visit per Claimant per Contract Year</i>	You pay \$20 Copayment per visit. After Copayment, Plan pays 100% of EME.	After Deductible, Plan pays 65% of EME and You pay balance of billed charges. 35% of EME will be applied toward Maximum Coinsurance.

Outpatient Physiotherapy Services and Speech Therapy

	Network Provider	Out-of-Network Provider
	You pay \$20 Copayment per visit. After Copayment, Plan pays 100% of EME.	After Deductible, Plan pays 65% of EME and You pay balance of billed charges. 35% of EME will be applied toward Maximum Coinsurance.

Prescription Drugs

Prescription Drugs are administered through 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 <i>Limited to \$500 for one professional exam and one GYN exam (for females) per Claimant per Contract Year. Limits do not apply to preventive care for Claimants through age 5</i>	You pay \$20 Copayment per visit. After Copayment, Plan pays 100% of EME.	After Deductible, Plan pays 65% of EME and You pay balance of billed charges. 35% of EME will be applied toward Maximum Coinsurance.
Screening Procedures (see Summary Plan Description for list) <i>Amounts paid are not included in the \$500 Limit above</i>	Plan pays 90% of EME and You pay 10% of EME. 10% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 65% of EME and You pay balance of billed charges. 35% of EME will be applied toward Maximum Coinsurance.

Professional Provider Services and Maternity Care

	Network Provider	Out-of-Network Provider
Professional services in connection with inpatient and outpatient Hospital, emergency department and all other facility care	Plan pays 90% of EME and You pay 10% of EME. 10% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 65% of EME and You pay balance of billed charges. 35% 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	Plan pays 90% of EME and You pay 10% of EME. 10% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 65% of EME and You pay balance of billed charges. 35% of EME will be applied toward Maximum Coinsurance.