

MEMBER

WELCOME GUIDE



HEALTH PLANS
UNIVERSITY OF UTAH

WELCOME

Thank you for choosing University of Utah Health Plans.

There are a few things you need to know about getting started with your plan. This guide will provide you with a quick overview of the following:

- [Member Portal](#)
- [ID Cards](#)
- [Benefits](#)
- [Health Plan Basics](#)
- [Accessing Your Benefits](#)
- [Your Health](#)
- [Key Terms](#)
- [Contact Information](#)

You will also find helpful links throughout this document to make it more convenient to find what you're looking for.

QUESTIONS?

Our Member Services Team is here to help! If you have questions about your current plan, we'll get you the answers you need.

MEMBER SERVICES

Monday - Friday, 8 am - 6 pm MST
801-213-4008 or toll free 833-981-0213



MEMBER PORTAL

Access your health plan information 24/7 through the member portal. To set up your free portal account:

1. Visit uhealthplan.utah.edu
2. Click "Member Login" in the upper-right corner of the navigation bar
3. On the portal home page, click "Register Here" under the new user section and enter your information

Or access the member portal directly via URL at MyUofUHealthPlans.org

DOWNLOAD THE APP

You can also access the portal via mobile app (available on both Android and iOS). To download the app, scan the QR code below with your phone's camera or search "UUHIPMembers" in the App Store or Google Play.



YOUR HEALTH PLAN AT YOUR FINGERTIPS

Our member portal is a one-stop shop for all of your health plan information. With a portal account, you can:

- View or print plan documents and benefit summaries
- Keep track of your deductible and out-of-pocket expense balances
- Select or change your primary care provider (PCP)
- Search for providers in your network by name, specialty or location
- Print temporary ID cards or request official ID cards in the mail
- Send messages and documents to the Customer Service Team
- Review your claims, explanation of benefits statements (EOBs), and other documents
- Access health and wellness information in the knowledge database
- View your eligibility for services



ID CARDS

Your ID card is for the following services: Medical, Pharmacy (Rx), and Behavioral Health. If dental coverage is part of your plan, you will receive a separate dental card from your dental plan administrator.

Please present your new ID card to your provider(s) for you and any of your enrolled dependents. Up-to-date claims submission and contact information is located on the back of your card.

ACCESS YOUR ID CARD THROUGH THE MEMBER PORTAL

You can access your ID card on the go, anywhere and anytime, through our member portal mobile app. You can also print or request mailed ID cards through the portal.

For instructions on how to register for the portal and download the mobile app, see the previous section titled **Member Portal**.



HEALTHCARE BLUEBOOK —

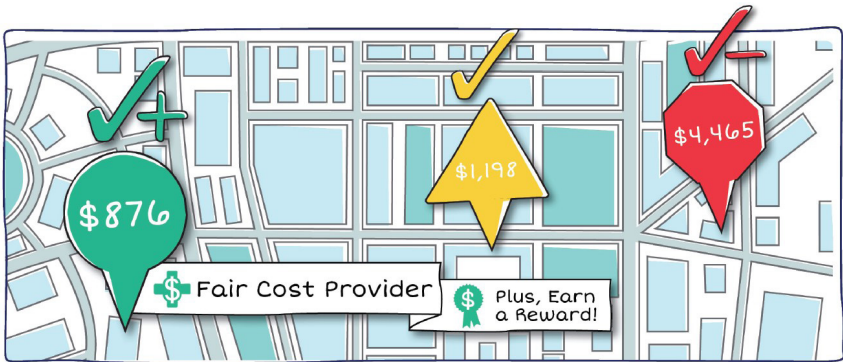
DID YOU KNOW

The price of a medical procedure from one facility to another can be different by hundreds or even thousands of dollars? It's true.

Now you have the power to see these price differences and choose where you go for your medical procedures. PLUS, we'll show you quality ratings for inpatient procedures.

This is a **FREE** benefit to you, so you can shop for medical care and save!

In just minutes you can search, find, and save on medical costs and find high-quality care. It doesn't have to be a mystery anymore.



✓+ Highest Quality

✓ Average Quality

✓- Lowest Quality

● At or Below FAIR PRICE

▲ Slightly Above FAIR PRICE

● Highest Price



HOW TO ACCESS HEALTHCARE BLUEBOOK

There are lots of ways you can access Healthcare Bluebook.

OPTION 1: Log on to the member portal, click the “My Resources” tab and choose “Cost and Quality Tool” in the drop-down menu.

OPTION 2: Visit the Healthcare Bluebook website at: healthcarebluebook.com/cc/uuhp

OPTION 3: Download the Healthcare Bluebook app in the App Store or Google Play.

COMPANY CODE: UUHP

Once you are redirected to the Healthcare Bluebook login screen, enter your last name, date of birth, and email address to log in.

Select your network and type a procedure in the search bar to find a fair price near you. You can also see quality scores for different facilities based on patient safety, mortality rates, and hospital readmissions.

BENEFITS

PLUS PLAN

Medical Care Deductible and Out of Pocket Maximum (OOPM)			
General Cost Share & Features	CTHS	In-Network	Out-of-Network
Deductible Medical Only	\$500 – self only \$500/\$1,000 – per person/family	\$1,000 – self only \$1,000/\$2,000 – per person/family	\$2,000 – self only \$2,000/\$4,000 – per person/family
Out-of-Pocket Maximum	\$4,500 – self only \$4,500/\$9,000 – per person/family	\$4,500 – self only \$4,500/\$9,000 – per person/family	\$9,000 – self only; \$9,000/\$18,000 – per person/family

Benefit	CTHS	In-Network	Out-of-Network
INPATIENT SERVICES*			
Inpatient Hospital, Surgical or Medical	20% AD	30% AD	50% AD
Maternity Physician Services	20% AD	30% AD	50% AD
Skilled Nursing Facility/Acute Rehab/Long Term Acute Care (Limited to 120 Days per calendar year)	30% AD	30% AD	50% AD
Hospice Care	20% AD	30% AD	50% AD
Mental Health or Substance Abuse Facility	20% AD	30% AD	50% AD
Residential Treatment Facility	20% AD	30% AD	50% AD
OUTPATIENT SERVICES*			
Telehealth/Medical**** (Provided through Amwell)	Not Applicable	No Charge	Not Applicable
Primary Care Provider Office Visits	\$20, Deductible does not apply	\$30, Deductible does not apply	50% AD
Specialist Office Visits	\$40, Deductible does not apply	\$50, Deductible does not apply	50% AD
After Hours or Urgent Care Clinic	\$40, Deductible does not apply	\$50, Deductible does not apply	50% AD

AD = After Deductible



Benefit	CTHS	In-Network	Out-of-Network
Mental Health or Substance Abuse Office Visit	\$40, Deductible does not apply	\$50, Deductible does not apply	50% AD
Physical Therapy (Limited to 30 visits per calendar year)	20% AD	30% AD	50% AD
Occupational Therapy (Limited to 30 visits per calendar year)	20% AD	30% AD	50% AD
Respiratory Therapy (Limited to 30 visits per calendar year)	20% AD	30% AD	50% AD
Speech Therapy (Limited to 30 visits per calendar year)	20% AD	30% AD	50% AD
Outpatient Surgical Services	20% AD	30% AD	50% AD
Other Medical Services Performed at an Outpatient Facility	20% AD	30% AD	50% AD
Allergy Treatment and Serum	20% AD	30% AD	50% AD
Major Diagnostic Services (X-ray, MRI, PET, and CT Scans)	20% AD	30% AD	50% AD
Minor Diagnostic Services (Lab)	No Charge	No Charge	50% AD
Emergency Room - Copay Waived if admitted to the hospital	\$200 - deductible does not apply	30% AD	50% AD
Emergency Physician and Professional Services	20% AD	30% AD	30% AD
Ambulance (Air or Ground) - Emergencies Only	Ground: N/A Air: N/A	Ground: \$100-deductible does not apply Air: 30% AD	Ground: \$100-deductible does not apply Air: 30% AD
PREVENTIVE SERVICES			
Primary Care Provider (PCP)	No Charge	No Charge	50% AD
Specialist	No Charge	No Charge	50% AD
Adult and Pediatric Immunizations	No Charge	No Charge	50% AD
Elective Immunizations (herpes zoster (shingles), rotavirus)*	No Charge	No Charge	50% AD
Minor Diagnostic Services	No Charge	No Charge	50% AD
Other Preventive Services	No Charge	No Charge	50% AD

AD = After Deductible

Benefit	CTHS	In-Network	Out-of-Network
OTHER BENEFITS*			
Durable Medical Equipment (DME)	Not Applicable	30% AD	50% AD
Injectable Drugs and Specialty Medications	20% AD	30% AD	50% AD
Bariatric Surgery (Limited to 1 treatment per lifetime)	Not Applicable	30% AD	50% AD
Hospice Care Provided at Home	Not Applicable	30% AD	50% AD
Home Health Care (Limited to 60 Visits per calendar year)	Not Applicable	30% AD	50% AD
Chiropractic & Acupuncture Services (Limited to 15 visits per calendar year)	Not Applicable	\$50, deductible does not apply	50% AD
Diabetic Education & Related Nutritional Counseling (Subject to CTH Program Guidelines)	No Charge	Not Applicable	Not Applicable
Nutritional Counseling (Limited to \$1,000 per calendar year)	No Charge	\$35, deductible does not apply	50% AD
Temporomandibular Joint (TMJ) (Limited to \$4,000 per lifetime, does not apply to out-of-pocket maximum)	Not Applicable	30% AD	50% AD
Medical Supplies	20% AD	30% AD	50% AD

AD = After Deductible



PRESCRIPTION BENEFITS*

General Cost Share & Features	CTHS	In-Network	Out-of-Network
Deductible	\$50 per person	\$50 per person	Not Covered

RETAIL PHARMACY – UP TO 30 DAY SUPPLY			
Benefit	CTHS	In-Network	Out-of-Network
Tier 0 (Preventive Drugs)	No Charge	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	\$15, deductible does not apply	\$15, deductible does not apply	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	\$60 AD	\$60 AD	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	Not Covered	Not Covered	Not Covered
Tier 4 (Preferred Specialty Drugs)	Not Covered	Not Covered	Not Covered

MAIL ORDER PHARMACY*** - UP TO 90 DAY SUPPLY - SELECTED DRUGS			
Benefit	CTHS	In-Network	Out-of-Network
Tier 0 (Preventive Drugs)	No Charge	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	\$30, deductible does not apply	\$30, deductible does not apply	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	\$60 AD	\$60 AD	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	Not Covered	Not Covered	Not Covered
Tier 4 (Preferred Specialty Drugs)	Not Covered	Not Covered	Not Covered

SPECIAL MAINTENANCE DRUG BENEFIT - LIMITED DRUG CATEGORIES			
Benefit	CTHS	In-Network	Out-of-Network
Tier 1 (Limited Preferred Generic Drugs on Special Maintenance List)	No Charge	No Charge	Not Covered
Tier 2 (Limited Preferred Brand and Non-Preferred Generic on Special Maintenance List)	No Charge	No Charge	Not Covered

Note: A limited number of medications fall under the Special Maintenance Drug Benefit. This benefit allows certain Tier 1 and Tier 2 prescriptions to be covered at no cost to members, without meeting deductible and/or out of pocket maximum. Medications designated under the Special Maintenance Drug benefit will show on the preferred drug list/formulary marked with an "M" indicating Special Maintenance Drug benefit.

NOTICES/NOTES/TERMS & CONDITIONS

* Preauthorization may be required. Generic medications required or member responsible for copay/coinsurance plus cost difference between brand name and generic medication

** Specialty Drugs require Prior Authorization and must be filled through a designated Specialty Pharmacy.

*** 90-day supply can be obtained through designated Mail Order Pharmacy and select network pharmacies, including any University of Utah Health Pharmacy, for Tier 0, 1, 2, and 3 drugs if covered.

**** If your plan has telehealth benefits listed only visits with your designated Telehealth Provider, Amwell, are eligible for the Telehealth/Medical or Telehealth/Mental Health benefit. Visits with a Primary Care Provider (PCP) or Specialist will be subject to the applicable copay, coinsurance, and/or deductible, even if the visit is electronic by phone or computer.

Deductible Included in Out of Pocket Maximum. All deductible, copay and coinsurance amounts are based on the allowed amounts and not on the provider's billed charges. You are responsible to pay for excess charges on covered services obtained from Out-of-Network providers and facilities. Excess charges are not applied to the Medical Out-of-Pocket Maximums.

To remain compliant with state and federal regulations, including the Affordable Care Act (ACA), these benefits are subject to change. (1) Primary Care Physicians are those with a primary specialty of General Medicine, Family Medicine, Internal Medicine, Pediatrics, and OB/Gyn. (2) Frequency and/or quantity limitations apply to some preventive care and medical supplies. (3) University of Utah Health Plans provides a \$4000 adoption indemnity as outlined by the state of Utah. Medical deductible, copay, or coinsurance listed under the benefit applies. (4) All covered services obtained outside the United States, except for urgent or emergency conditions, will be paid at the Out-of-Network benefit. (5) Certain exclusions or preauthorization may apply for services and prescription drugs. Please refer to your policy for more information.

For more information, please call Customer Service at 833-661-3915 or 833-661-3915 from 8:00 am to 6:00 pm, Monday – Friday <https://uhealthplan.utah.edu/carsontahoe/>

In-Network benefits will be applied to all Nevada providers within the Network and all out of state providers in the First Health Network. All benefits are administered by University of Utah Health Plans.



CORE PLAN

Medical Care Deductible and Out of Pocket Maximum (OOPM)			
General Cost Share & Features	CTHS	In-Network	Out-of-Network
Deductible Medical Only	\$1,000 – self only	\$1,500 – self only	\$3,000 – self only
	\$1,000/\$2,000 – per person/family	\$1,500/\$3,000 – per person/family	\$3,000/\$6,000 – per person/family
Out-of-Pocket Maximum	\$6,850 – self only	\$6,850 – self only	\$12,000 – self only;
	\$6,850/\$13,700 – per person/family	\$6,850/\$13,700 – per person/family	\$12,000/\$24,000 – per person/family

Benefit	CTHS	In-Network	Out-of-Network
INPATIENT SERVICES*			
Inpatient Hospital, Surgical or Medical	20% AD	30% AD	50% AD
Maternity Physician Services	20% AD	30% AD	50% AD
Skilled Nursing Facility/Acute Rehab/Long Term Acute Care (Limited to 120 Days per calendar year)	30% AD	30% AD	50% AD
Hospice Care	20% AD	30% AD	50% AD
Mental Health or Substance Abuse Facility	20% AD	30% AD	50% AD
Residential Treatment Facility	20% AD	30% AD	50% AD
OUTPATIENT SERVICES*			
Telehealth/Medical**** (Provided through Amwell)	Not Applicable	No Charge	Not Applicable
Primary Care Provider Office Visits	\$25, Deductible does not apply	\$35, Deductible does not apply	50% AD
Specialist Office Visits	\$40, Deductible does not apply	\$50, Deductible does not apply	50% AD
After Hours or Urgent Care Clinic	\$40, Deductible does not apply	\$50, Deductible does not apply	50% AD

AD = After Deductible

Benefit	CTHS	In-Network	Out-of-Network
Mental Health or Substance Abuse Office Visit	\$40, Deductible does not apply	\$50, Deductible does not apply	50% AD
Physical Therapy (Limited to 30 visits per calendar year)	20% AD	30% AD	50% AD
Occupational Therapy (Limited to 30 visits per calendar year)	20% AD	30% AD	50% AD
Respiratory Therapy (Limited to 30 visits per calendar year)	20% AD	30% AD	50% AD
Speech Therapy (Limited to 30 visits per calendar year)	20% AD	30% AD	50% AD
Outpatient Surgical Services	20% AD	30% AD	50% AD
Other Medical Services Performed at an Outpatient Facility	20% AD	30% AD	50% AD
Allergy Treatment and Serum	20% AD	30% AD	50% AD
Major Diagnostic Services (X-ray, MRI, PET, and CT Scans)	20% AD	30% AD	50% AD
Minor Diagnostic Services (Lab)	No Charge	No Charge	50% AD
Emergency Room - Copay Waived if admitted to the hospital	\$200 - deductible does not apply	30% AD	50% AD
Emergency Physician and Professional Services	20% AD	30% AD	30% AD
Ambulance (Air or Ground) - Emergencies Only	Ground: N/A Air: N/A	Ground: \$100-deductible does not apply Air: 30% AD	Ground: \$100-deductible does not apply Air: 30% AD
PREVENTIVE SERVICES			
Primary Care Provider (PCP)	No Charge	No Charge	50% AD
Specialist	No Charge	No Charge	50% AD
Adult and Pediatric Immunizations	No Charge	No Charge	50% AD
Elective Immunizations (herpes zoster (shingles), rotavirus)*	No Charge	No Charge	50% AD
Minor Diagnostic Services	No Charge	No Charge	50% AD
Other Preventive Services	No Charge	No Charge	50% AD

AD = After Deductible



Benefit	CTHS	In-Network	Out-of-Network
OTHER BENEFITS*			
Durable Medical Equipment (DME)	Not Applicable	30% AD	50% AD
Injectable Drugs and Specialty Medications	20% AD	30% AD	50% AD
Bariatric Surgery (Limited to 1 treatment per lifetime)	Not Applicable	30% AD	50% AD
Hospice Care Provided at Home	Not Applicable	30% AD	50% AD
Home Health Care (Limited to 60 Visits per calendar year)	Not Applicable	30% AD	50% AD
Chiropractic & Acupuncture Services (Limited to 15 visits per calendar year)	Not Applicable	\$50, deductible does not apply	50% AD
Diabetic Education & Related Nutritional Counseling (Subject to CTH Program Guidelines)	No Charge	Not Applicable	Not Applicable
Nutritional Counseling (Limited to \$1,000 per calendar year)	No Charge	\$35, deductible does not apply	50% AD
Temporomandibular Joint (TMJ) (Limited to \$4,000 per lifetime, does not apply to out-of-pocket maximum)	Not Applicable	30% AD	50% AD
Medical Supplies	20% AD	30% AD	50% AD

AD = After Deductible

PRESCRIPTION BENEFITS*

General Cost Share & Features	CTHS	In-Network	Out-of-Network
Deductible	\$50 per person	\$50 per person	Not Covered

RETAIL PHARMACY – UP TO 30 DAY SUPPLY			
Benefit	CTHS	In-Network	Out-of-Network
Tier 0 (Preventive Drugs)	No Charge	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	\$15, deductible does not apply	\$15, deductible does not apply	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	\$30 AD	\$30 AD	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	\$60 AD	\$60 AD	Not Covered
Tier 4 (Preferred Specialty Drugs)**	20% AD	20% AD	Not Covered

MAIL ORDER PHARMACY*** - UP TO 90 DAY SUPPLY – SELECTED DRUGS			
Benefit	CTHS	In-Network	Out-of-Network
Tier 0 (Preventive Drugs)	No Charge	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	\$30, deductible does not apply	\$30, deductible does not apply	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	\$60 AD	\$60 AD	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	Not Covered	Not Covered	Not Covered
Tier 4 (Preferred Specialty Drugs)	Not Covered	Not Covered	Not Covered

SPECIAL MAINTENANCE DRUG BENEFIT - LIMITED DRUG CATEGORIES			
Benefit	CTHS	In-Network	Out-of-Network
Tier 1 (Limited Preferred Generic Drugs on Special Maintenance List)	No Charge	No Charge	Not Covered
Tier 2 (Limited Preferred Brand and Non-Preferred Generic on Special Maintenance List)	No Charge	No Charge	Not Covered



Note: A limited number of medications fall under the Special Maintenance Drug Benefit. This benefit allows certain Tier 1 and Tier 2 prescriptions to be covered at no cost to the members, without meeting deductible and/or out of pocket maximum. Medications designated under the Special Maintenance Drug benefit will show on the preferred drug list/formulary marked with an "M" indicating Special Maintenance Drug benefit.

NOTICES/NOTES/TERMS & CONDITIONS

* Preauthorization may be required. Generic medications required or member responsible for copay/coinsurance plus cost difference between brand name and generic medication

** Specialty Drugs require Prior Authorization and must be filled through a designated Specialty Pharmacy.

*** 90-day supply can be obtained through designated Mail Order Pharmacy and select network pharmacies, including any University of Utah Health Pharmacy, for Tier 0, 1, 2, and 3 drugs if covered.

**** If your plan has telehealth benefits listed only visits with your designated Telehealth Provider, Amwell, are eligible for the Telehealth/Medical or Telehealth/Mental Health benefit. Visits with a Primary Care Provider (PCP) or Specialist will be subject to the applicable copay, coinsurance, and/or deductible, even if the visit is electronic by phone or computer.

Deductible Included in Out of Pocket Maximum. All deductible, copay and coinsurance amounts are based on the allowed amounts and not on the provider's billed charges. You are responsible to pay for excess charges on covered services obtained from Out-of-Network providers and facilities. Excess charges are not applied to the Medical Out-of-Pocket Maximums.

To remain compliant with state and federal regulations, including the Affordable Care Act (ACA), these benefits are subject to change. (1) Primary Care Physicians are those with a primary specialty of General Medicine, Family Medicine, Internal Medicine, Pediatrics, and OB/Gyn. (2) Frequency and/or quantity limitations apply to some preventive care and medical supplies. (3) All covered services obtained outside the United States, except for urgent or emergency conditions, will be paid at the Out-of-Network benefit. (4) Certain exclusions or preauthorization may apply for services and prescription drugs. Please refer to your policy for more information.

For more information, please call Customer Service at 833-661-3915 or 833-661-3915 from 8:00 am to 6:00 pm, Monday – Friday. <https://uhealthplan.utah.edu/carsontahoe/>

All benefits are administered by University of Utah Health Plans.

BENEFITS

HDHP PLAN

Medical Care Deductible and Out of Pocket Maximum (OOPM)			
General Cost Share & Features	CTHS	In-Network	Out-of-Network
Deductible Medical Only	\$3,300 – self only	\$4,100 – self only	\$6,100 – self only
	\$3,300/\$6,400 – per person/family	\$4,100/\$8,200 – per person/family	\$6,100/\$12,200 – per person/family
Out-of-Pocket Maximum	\$5,000 – self only	\$5,000 – self only	\$10,000 – self only;
	\$5,000/\$10,000 – per person/family	\$5,000/\$10,000 – per person/family	\$10,000/\$20,000 – per person/family

Benefit	CTHS	In-Network	Out-of-Network
INPATIENT SERVICES*			
Inpatient Hospital, Surgical or Medical	20% AD	30% AD	50% AD
Maternity Physician Services	20% AD	30% AD	50% AD
Skilled Nursing Facility/Acute Rehab/Long Term Acute Care (Limited to 120 Days per calendar year)	30% AD	30% AD	50% AD
Hospice Care	20% AD	30% AD	50% AD
Mental Health or Substance Abuse Facility	20% AD	30% AD	50% AD
Residential Treatment Facility	20% AD	30% AD	50% AD
OUTPATIENT SERVICES*			
Telehealth/Medical**** (Provided through Amwell)	Not Applicable	No Charge	Not Applicable
Primary Care Provider Office Visits	20% AD	30% AD	50% AD
Specialist Office Visits	20% AD	30% AD	50% AD
After Hours or Urgent Care Clinic	20% AD	30% AD	50% AD

AD = After Deductible



Benefit	CTHS	In-Network	Out-of-Network
Mental Health or Substance Abuse Office Visit	20% AD	30% AD	50% AD
Physical Therapy (Limited to 30 visits per calendar year)	20% AD	30% AD	50% AD
Occupational Therapy (Limited to 30 visits per calendar year)	20% AD	30% AD	50% AD
Respiratory Therapy (Limited to 30 visits per calendar year)	20% AD	30% AD	50% AD
Speech Therapy (Limited to 30 visits per calendar year)	20% AD	30% AD	50% AD
Outpatient Surgical Services	20% AD	30% AD	50% AD
Other Medical Services Performed at an Outpatient Facility	20% AD	30% AD	50% AD
Allergy Treatment and Serum	20% AD	30% AD	50% AD
Major Diagnostic Services (X-ray, MRI, PET, and CT Scans)	20% AD	30% AD	50% AD
Minor Diagnostic Services (Lab)	20% AD	30% AD	50% AD
Emergency Room	20% AD	30% AD	50% AD
Emergency Physician and Professional Services	20% AD	30% AD	30% AD
Ambulance (Air or Ground) - Emergencies Only	Ground: N/A Air: N/A	Ground: 30% AD Air: 30% AD	Ground: 30% AD Air: 30% AD
PREVENTIVE SERVICES			
Primary Care Provider (PCP)	No Charge	No Charge	50% AD
Specialist	No Charge	No Charge	50% AD
Adult and Pediatric Immunizations	No Charge	No Charge	50% AD
Elective Immunizations (herpes zoster (shingles), rotavirus)*	No Charge	No Charge	50% AD
Minor Diagnostic Services	No Charge	No Charge	50% AD
Other Preventive Services	No Charge	No Charge	50% AD

AD = After Deductible

Benefit	CTHS	In-Network	Out-of-Network
OTHER BENEFITS*			
Durable Medical Equipment (DME)	Not Applicable	30% AD	50% AD
Injectable Drugs and Specialty Medications	20% AD	30% AD	50% AD
Bariatric Surgery (Limited to 1 treatment per lifetime)	Not Applicable	30% AD	50% AD
Hospice Care Provided at Home	Not Applicable	30% AD	50% AD
Home Health Care (Limited to 60 Visits per calendar year)	Not Applicable	30% AD	50% AD
Chiropractic & Acupuncture Services (Limited to 15 visits per calendar year)	Not Applicable	\$50, deductible dos not apply	50% AD
Diabetic Education & Related Nutritional Counseling (Subject to CTH Program Guidelines)	20% AD	Not Applicable	Not Applicable
Nutritional Counseling (Limited to \$1,000 per calendar year)	20% AD	\$35, deductible dos not apply	50% AD
Temporomandibular Joint (TMJ) (Limited to \$4,000 per lifetime, does not apply to out-of-pocket maximum)	Not Applicable	30% AD	50% AD
Medical Supplies	20% AD	30% AD	50% AD

AD = After Deductible



PRESCRIPTION BENEFITS*

RETAIL PHARMACY – UP TO 30 DAY SUPPLY			
Benefit	CTHS	In-Network	Out-of-Network
Tier 0 (Preventive Drugs)	No Charge	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	20% AD	20% AD	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	20% AD	20% AD	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	20% AD	20% AD	Not Covered
Tier 4 (Preferred Specialty Drugs)	20% AD	20% AD	Not Covered

MAIL ORDER PHARMACY*** - UP TO 90 DAY SUPPLY - SELECTED DRUGS			
Benefit	CTHS	In-Network	Out-of-Network
Tier 0 (Preventive Drugs)	No Charge	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	20% AD	20% AD	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	20% AD	20% AD	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	Not Covered	Not Covered	Not Covered
Tier 4 (Preferred Specialty Drugs)	Not Covered	Not Covered	Not Covered

SPECIAL MAINTENANCE DRUG BENEFIT - LIMITED DRUG CATEGORIES			
Benefit	CTHS	In-Network	Out-of-Network
Tier 1 (Limited Preferred Generic Drugs on Special Maintenance List)	No Charge	No Charge	Not Covered
Tier 2 (Limited Preferred Brand and Non-Preferred Generic on Special Maintenance List)	No Charge	No Charge	Not Covered

Note: A limited number of medications fall under the Special Maintenance Drug Benefit. This benefit allows certain Tier 1 and Tier 2 prescriptions to be covered at no cost to members, without meeting deductible and/or out of pocket maximum. Medications designated under the Special Maintenance Drug benefit will show on the preferred drug list/formulary marked with an "M" indicating Special Maintenance Drug benefit.

NOTICES/NOTES/TERMS & CONDITIONS

* Preauthorization may be required. Generic medications required or member responsible for copay/coinsurance plus cost difference between brand name and generic medication.

** Specialty Drugs require Prior Authorization and must be filled through a designated Specialty Pharmacy.

*** 90-day supply can be obtained through designated Mail Order Pharmacy and select network pharmacies, including any University of Utah Health Pharmacy, for Tier 0, 1, 2, and 3 drugs if covered.

**** If your plan has telehealth benefits listed only visits with your designated Telehealth Provider, Amwell, are eligible for the Telehealth/Medical or Telehealth/Mental Health benefit. Visits with a Primary Care Provider (PCP) or Specialist will be subject to the applicable copay, coinsurance, and/or deductible, even if the visit is electronic by phone or computer.

Deductible Included in Out of Pocket Maximum. All deductible, copay and coinsurance amounts are based on the allowed amounts and not on the provider's billed charges. You are responsible to pay for excess charges on covered services obtained from Out-of-Network providers and facilities. Excess charges are not applied to the Medical Out-of-Pocket Maximums.

To remain compliant with state and federal regulations, including the Affordable Care Act (ACA), these benefits are subject to change. (1) Primary Care Physicians are those with a primary specialty of General Medicine, Family Medicine, Internal Medicine, Pediatrics, and OB/Gyn. (2) Frequency and/or quantity limitations apply to some preventive care and medical supplies. (3) University of Utah Health Plans provides a \$4000 adoption indemnity as outlined by the state of Utah. Medical deductible, copay, or coinsurance listed under the benefit applies. (4) All covered services obtained outside the United States, except for urgent or emergency conditions, will be paid at the Out-of-Network benefit. (5) Certain exclusions or preauthorization may apply for services and prescription drugs. Please refer to your policy for more information.

For more information, please call Customer Service at 833-661-3915 or 833-661-3915 from 8:00 am to 6:00 pm, Monday – Friday <https://uhealthplan.utah.edu/carsontahoe/>

All benefits are administered by University of Utah Health Plans.



DENTAL PLAN

CALENDAR YEAR MAXIMUM BENEFITS	
Dependent child up to age 19 All others	Unlimited \$1,500
ORTHODONTIC LIFETIME MAXIMUM	\$1,000
CALENDAR YEAR DEDUCTIBLE	
Individual Deductible Family Maximum Deductible	\$75 \$225
<p>Individual Deductible - The Individual Calendar Year Deductible is an amount which a Covered Person must contribute toward payment of eligible dental expenses.</p> <p>Family Maximum Deductible - If \$225 in eligible dental expenses is incurred collectively by family members during a Calendar Year, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.</p>	

ELIGIBLE DENTAL EXPENSES	MEMBER RATES
Preventive Services (Deductible waived)	No Charge
<p>Limits applicable to certain Preventive Services:</p> <ul style="list-style-type: none"> • Routine oral examinations and cleanings are limited to 2 exams/cleanings per Calendar Year • Fluoride treatment is limited to children under the age of 19; 1 per Calendar Year • Sealants are limited to children under the age of 19; 1 per year • Full-mouth X-rays are limited to 1 per 3-year period • Routine bitewings are limited to 2 Sets per Calendar Year 	
Basic Services	20% AD
Major Service	50% AD
Orthodontic Services	50% AD

For questions, contact Customer Service at 833-661-3915 or [ddsppo.com](https://www.ddsppo.com)

MORE BENEFITS INFO

SUMMARY OF BENEFITS AND COVERAGE (SBC)

As part of the Affordable Care Act, health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about a health plan's medical, pharmacy, and behavioral health benefits, coverage, and exclusions. This regulation is designed to help you better understand and evaluate your health insurance choices. Click [HERE](#) or log on to the member portal to view the most current Provider Directory and SBC.

EXPLANATION OF BENEFITS (EOB)

An EOB statement is created each time you receive care. It explains how your claim was processed and lists the amount you are responsible to pay to the provider.

You can access and review your EOB(s) through the member portal at MyUofUHealthPlans.org or on the member portal mobile app. Refer to the Member Portal section for registration information.



NETWORK

Your provider network is identified by the logo on your ID Card. To receive benefits, you must use doctors, clinics, and hospitals that participate in your network.

To find a participating provider, log on to the member portal and click “Find a Doctor or Facility” or call Member Services for assistance at 833-661-3915

UNDERSTANDING YOUR NETWORK

Your provider network offers access to a variety of doctors for you to choose from. If you have out-of-network coverage, you also have the option to seek care from providers not listed in the Universal Health network, but it’s important to note that their services could have higher out-of-pocket costs. Members may seek care from in-network specialists, including behavioral health providers, without a referral. When non-emergent hospital care is needed, your doctor will help you get care at a network facility.

For information regarding your provider network or network doctor’s qualifications, contact our Member Services Team at 833-661-3915 or visit uhealthplan.utah.edu/carsontahoe/providers or the website listed on the back of your ID Card.

SELECTING YOUR PRIMARY CARE PROVIDER (PCP)

You can select or change your PCP through the member portal at MyUofUHealthPlans.org. Routinely visiting a PCP can lower your medical costs and help you maintain a healthy lifestyle. If you need help finding a doctor, contact our Member Services Team. They can help you find the closest doctor with the most immediately available appointment, and they can schedule appointments for you.

URGENT CARE

Because you can't plan to be sick or injured between 8:00 to 5:00, evening and weekend care is available for situations that are not life-threatening, such as:

- Flu and fever
- Earaches
- Nausea
- Rashes/allergic reactions
- Animal and insect bites
- Sprains/minor fractures
- Minor cuts requiring stitches
- Urinary tract/ bladder infections

In-network urgent cares in Nevada:

FACILITY	PHONE	HOURS
CARSON CITY		
Carson Tahoe Urgent Care	775-445-7330	7 days a week, 8am - 8:30pm
DAYTON		
Carson Tahoe Urgent Care	775-445-7330	Mon - Fri: 8am-6:30pm Sat: 9am - 5pm
ELKO		
A+ Urgent Care	777-777-7587	Mon-Fri: 8am-7:30pm Sat: 8am-4pm, Sun: 8am-12pm
Aspen Quick Care	775-993-2800	7 days a week, 8am-8pm

FACILITY	PHONE	HOURS
ELKO		
Pioneer Urgent Care	775-738-2034	Mon – Thurs 9am – 5pm Fri 10am – 1pm
FALLON		
Narag Fallon Family Clinic	775-428-2747	Mon – Fri 8am – 5pm
INCLINE VILLAGE		
Incline Village Urgent Care	775-833-2929	Mon – Fri 9am – 5pm Sat 9am – 12pm
MINDEN		
Ironwood Urgent Care	775-782-1610	Mon – Fri 8am – 7pm Sat 9am – 5pm
RENO		
Concentra Urgent Care	775-322-5757	Mon – Fri 8am – 6pm Sat 9am – 4pm
Dispachhealth NV (mobile)	775-419-2170	7 days a week, 8am-10pm
Northern Nevada Urgent Care	775-851-1583	Mon – Fri 9am – 7pm Sat – Sun 9am – 5pm
Saint Mary's Urgent Care at Galena	775-770-7210	Mon – Fri 7am – 7pm Sat – Sun 9am – 5pm
Saint Mary's Urgent Care at Sharlands	775-770-7580	Mon – Fri 7am – 7pm Sat – Sun 9am – 5pm
United Pain Urgent Care	775-384-1380	7 days a week, 8am-7pm
SOUTH LAKE TAHOE		
Tahoe Urgent Care	530-541-3277	7 days a week, 8am-5pm
SPARKS		
Concentra Urgent Care	775-356-8181	Mon – Fri 7am – 6pm
Northern Nevada Urgent Care	775-355-5010	Mon – Fri 9am – 7pm Sat – Sun 9am – 5pm
Saint Mary's Urgent Care at Spanish Springs	775-770-7727	Mon – Fri 7am – 7pm Sat – Sun 9am – 5pm
SPRING CREEK		
Aspen Quick Care	775-738-3000	7 Days a week, 8am – 8pm
STATELINE		
Stateline Medical Center	775-589-8900	Mon – Fri 8am – 6pm Sat – Sun 9am – 5pm

EMERGENCY CARE

If you experience an emergency, call 911 or go to the nearest hospital.

HOSPITALS

U of U Health Plans offers access to many local, award-winning hospitals. To view a comprehensive list of in-network hospitals, visit uhealthplan.utah.edu/carsontahoe/providers or the website listed on the back of your ID Card.

OUTSIDE OF NEVADA

Coverage for urgent and emergency care outside of Nevada is available through the [First Health](#) network. To find In-Network Providers, call Member Services at 833-661-3915, log on to your member portal account, or visit the website listed on the back of your ID card.

OUTSIDE OF THE UNITED STATES

If you are traveling outside of the country and need urgent or emergency care, visit the nearest doctor or hospital. You may need to pay for the treatment at the time of service. Some services received outside of the United States require preauthorization. Call Member Services at 833-661-3915 for details.



YOUR HEALTH

Our care and utilization management teams are led by distinguished physicians, highly skilled nurses, and care coordinators that help members navigate the health care system to improve their health care experience, resulting in the best outcomes while providing cost-effective care.

OUR PROGRAMS

Our programs are built around population health, disease management, and quality improvement. The program teams help members get the right care at the right time to allow for the best outcome based on nationally recognized evidence-based guidelines.

- Quality Improvement
- U Baby
- Pediatric Special Needs
- Health and Wellness
- Adult Complex Needs
- Inpatient Navigator

The Quality Program continuously works to improve the services offered by our staff and network providers and our clinical outcomes. To learn more about our programs visit uhealthplan.utah.edu/care-management/programs

HEALTH RISK ASSESSMENT

Our care management team offers you the opportunity to complete a free, confidential, and voluntary Health Risk Assessment (HRA) to see how healthy you are. The HRA identifies personal risk factors and provides an action plan to help prevent future conditions or manage current conditions.

This program entitles you to work one on one with a nurse care manager. It is our goal to help you get the best possible care.

DENTAL

Diversified Dental Services (DDS):

A dental PPO network with general and specialty dentists practicing throughout the state of Nevada. This dental network is available for Carson Tahoe Health employees and their covered family members only.

Visit DiversifiedDental.com for more info.

FILING / SUBMITTING A CLAIM

University of Utah Health Plans
Attention: Claims Department
PO Box 45180
Salt Lake City, UT 84145-0180

Participating providers will file claims for you. However, if you need to file a claim from a non-participating provider or submit a paid claim for reimbursement, call Member Services at 801-213-4008 to find out what information is needed or visit uhealthplan.utah.edu.



INTERPRETER SERVICES

We have interpreters for any language. Call Member Services to ask for help finding a doctor who speaks your language. You can also find this information on our website in the Provider Directory. Telephone relay services, or TTY/TDD, are also available by calling Utah Relay Services at 711 or 1-800-346-4128. TDD/TTY services are also available for care and utilization management services.

KEY TERMS

ALLOWED AMOUNT

The dollar amount allowed for a specific covered service.

COPAY*

A fixed amount that you must pay for covered services to a provider or facility.

COINSURANCE

A fixed percentage of the allowed amount you pay toward health care after meeting your deductible.

COVERED DEPENDENT

A member of your family who meets the eligibility requirements to be covered by your plan and whom you have enrolled on your plan.

DEDUCTIBLE*

A fixed amount that you must pay each year for covered services before we make a payment. Some categories of benefits may be subject to separate deductibles.

EFFECTIVE DATE

The date that coverage for you and your covered dependent(s) begins. It may be different from the eligibility, contract, and/or anniversary date.

EXPLANATION OF HEALTH CARE BENEFITS (EOB)

A document describing how a claim has been processed. EOBs outline the services provided, the amount billed, payment made, and any costs that are your responsibility.

NETWORK PROVIDER

A health professional, a supplier of health items, or a health care facility that has an agreement or contract with U of U Health Plans to provide or coordinate covered services to you.

OUT-OF-NETWORK PROVIDER

Any provider not under contract to deliver covered services to you.

OUT-OF-POCKET MAXIMUM

The most you will pay in coinsurance and deductible for covered health care services and prescription drugs.

PRIMARY CARE PROVIDER (PCP)

A physician you may select within the panel of participating providers who will provide and coordinate your health care.



PRIVACY NOTICE

U of U Health Plans is legally required to protect the privacy of each member's health information, and doing so is of extreme importance. Protected Health Information (PHI) includes your personal and demographic information that identifies you and that relates to your past, present, or future physical or mental health condition and related health care services. Please visit uhealthplan.utah.edu to read the Notice of Privacy Practices.

If you would like a free copy of these materials printed and mailed to you, please contact our Member Services Team at 833-661-3915.

RIGHTS AND RESPONSIBILITIES

U of U Health Plans wants to give you the best care and service. As a University of Utah Health Plans member, you have rights and responsibilities. To see these Rights and Responsibilities in detail please, visit uhealthplan.utah.edu.

COBRA

Some U of U Health Plans group plans may entitle you to COBRA benefits if you or your family members lose your health care coverage. Please refer to our website, uhealthplan.utah.edu, to see our Notice Of Continuation Of Coverage Rights (COBRA).

COMPLAINTS, GRIEVANCES, AND APPEALS

You have the right to make a complaint or ask for reconsideration of a decision related to an authorization, service, benefit, or plan policy. You also have the right to an independent, external review of final internal UM determinations. To file a complaint or appeal, visit uhealthplan.utah.edu or contact our Member Services Team at 833-661-3915.

OTHER

ADVANCING MEDICAL TECHNOLOGIES

U of U Health Plans evaluates advances in technology to make sure that members have fair access to safe and effective care. This includes medical and behavioral healthcare procedures, drugs, and devices. To be included in your plan, the technology must meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;
2. Scientific studies showing conclusive evidence of improved net health outcome;
3. The use of the technology is in accordance with standards of good medical practice.

COVERAGE DECISIONS

All utilization review decisions and care management actions are based on a determination of appropriateness of care and service according to the benefit coverage for the member. U of U Health Plans provides no incentive or reward for issuing denials of coverage. There is no use of incentives to encourage barriers to care and services. Utilization Review decisions are based on nationally recognized criteria, plan benefits, and adherence of utilization management policies and procedures.



YEARLY NOTICES

U of U Health Plans wants to give our members the best service and care. As a health plan, we have a responsibility to notify and update our members on a yearly basis. Please review the following notices and contact us with any questions.

University of Utah Health Plans

6056 Fashion Square Drive, Suite 3104, Murray, UT 84107

Phone: 833-661-3915

Email: uuhp@hsc.utah.edu

Website: uhealthplan.utah.edu

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

The Newborns' Act defines the amount of time you and your newborn child are covered for a hospital stay following childbirth. For a vaginal delivery, you can stay in the hospital for up to 48 hours. For a C-section, you can stay in the hospital for up to 96 hours. However, your provider may decide, after talking to you, to let you or your newborn leave the hospital earlier. For more information on the Newborns' Act, please visit www.dol.gov/ebsa/newsroom/fsnmhafs.html.

TRAVELING

When traveling outside of Utah, you are covered for urgent and emergency care. U of U Health Plans has an agreement with one of the largest national provider networks. Using these providers will cost you less. To find in-network providers, call Member Services or visit our website.

LANGUAGE

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de University of Utah Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-443-3440.

Chinese: 如果您, 或是您正在協助的對象, 有關於[插入SBM項目的名稱 University of Utah Health Plans 方面的問題, 您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員, 請撥電話 [在此插入數字 1-833-443-3440.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về University of Utah Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-833-443-3440.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 University of Utah Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-443-3440 로 전화하십시오.

Navajo: Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-443-3440.

Nepali: य"द तपा' आ)ना ला"द आफ- आवेिनको काम ििै, वा कसलै ई म8दत ििै हुनहु;छ, University of Utah Health Plans बारे?@नहA छन् भने आ)नो मातृभाषामा दन:शुGक सहायता वा जानकारी पाउने अ"दकार छ । िोभाषे (इ;टर?टर) सँ ि कुरा िनुःपु रे 1-833-443-3440 मा फोन िनुःहुोस।

Tongan: 'O kapau 'oku i ai ha'o fehu'i, pe ha fehu'i mei ha tokotaha 'oku ke tokoni ki ai, 'o kau ki he University of Utah Health Plans, 'oku ke ma'u 'a e totonu ke ma'u ha fakahinohino mo e tokoni 'i ho'o lea fakafonua ta'etotongi. Ke talanoa mo ha tokotaha fakatonu lea, tā ki he fika ko 'eni 1-833-443-3440.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o University of Utah Health Plans, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-833-443-3440.



Tagalog: Kung ikaw, o ang iyong tinutulungan, ay may mga atanungan tungkol sa University of Utah Health Plans, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-443-3440.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum University of Utah Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-833-443-3440 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу University of Utah Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-833-443-3440.

Arabic: إذا كانت لديك، أو لدى أي شخص تساعد، أسئلة حول University of Utah Health Plans، ف لديك الحق في الحصول على المساعدة والمعلومات بلغتك دون أي تكلفة. للتحدث مع مترجم، اتصل بالرقم 1-833-443-3440.

Mon-Khmer, Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពីគម្រោងសុខភាពរបស់សាកលវិទ្យាល័យយូថាហ្វ អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មានជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខ 1-833-443-3440.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de University of Utah Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-833-443-3440.

Japanese: ご本人様、またはお客様の身の回りの方でも、University of Utah Health Plans についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報入手したりすることができます。料金はかかりません。通訳とお話される場合、1-833-443-3440 までお電話ください

CONTACT US

MEMBER SERVICES

Toll Free: (833) 661-3915

Fax: (801) 281-6121

uuhp@hsc.utah.edu

CLAIMS/ELIGIBILITY

(833) 661-3915

CASE MANAGEMENT & UTILIZATION REVIEW

(833) 661-3915

PROVIDER RELATIONS

(801) 587-2838

provider.relations@hsc.utah.edu

SUBMIT CLAIMS TO:

University of Utah Health Plans

Attention: Claims Department

PO Box 45180

Salt Lake City, UT 84145-0180





HEALTH PLANS
UNIVERSITY OF UTAH

833-661-3915

uhealthplan.utah.edu