Utah Basic Plus

HSA Plan for State of Utah

Deductible » $3,000 Single | **$6,000** Double & Family

Cost Sharing » 70/30 Coinsurance for Medical and RX

Maximum Out-of-Pocket » $6,050 Single | **$12,100** Double & Family

State HSA Contribution » $1,725 Single | **$3,450** Double & Family

Annual Premium Savings » $690 Single | **$1,380** Double & Family

» Catastrophic plan with basic benefit package.

» Covers 10 essential health benefit categories.

» Does not add to state-mandated coverages.

» Known vs. unknown aspects of federal law.

» Amendable as matter of state or federal law.

AMBULATORY PATIENT SERVICE » ELIGIBLE EXPENSES

Plan pays 70% after deductible for these services:

» All outpatient surgeries other than those listed in exclusions.

» Breast reconstructive surgery under WHRCA.

» Office visits to primary care providers and specialists (without referral) for eligible services and conditions.

EXCLUSIONS | No coverage for:

» Cosmetic surgery.

» Assisted reproductive technology.

» Gender reassignment surgery.

» Experimental or investigational procedures.

» Hair transplants.

» Treatment for developmental delay.

» Fitness programs.

» Childbirth education classes.

» Massage therapy.

» Medical necessity.

» TMJ treatment.

» Office injections for allergies.

» Infertility.

» Any surgeries covered at 50% under Traditional and Star Plan (examples: breast reduction, eye lid surgery).

» Sleep studies.

» Spinal cord stimulators.

» Chiropractic care.

EMERGENCY SERVICE » ELIGIBLE EXPENSES

Plan pays 70% after deductible for these services:

» Emergency transport to nearest facility, air ambulance included if medically necessary.

» Emergency room services are covered for life-threatening and urgent conditions as determined by the plan.

» Physician visits while in the emergency room.

» Medically necessary diagnostic services and surgeries.

Coverage limited to emergency conditions.

HOSPITALIZATION » ELIGIBLE EXPENSES

Plan pays 70% after deductible for these services:

» Inpatient surgeries covered by the plan.

» Hospital stays to treat a covered condition.

» Hospice services.

EXCLUSION:

» No coverage for any surgery covered at 50% under Traditional and STAR (examples: breast reduction, eye lid surgery).

PEHP

SEE OTHER SIDE

Utah Basic Plus, Continued

MATERNITY AND NEWBORN » ELIGIBLE EXPENSES

Covers all medically necessary charges for maternity and newborn care including:

» Hospital.

» Physician.

» Labs.

» Ultrasounds.

MENTAL HEALTH AND SUBSTANCE ABUSE » ELIGIBLE EXPENSES

» Outpatient, up to 8 visits/year.

» Inpatient, up to 30 days/year.

EXCLUSIONS | No coverage for:

» Residential treatment facilities/ group homes.

» Behavior modification services.

PRESCRIPTION DRUGS COVERAGE » ELIGIBLE EXPENSES

» Coverage limited to a single formulary with mostly generics, essential brand names only, and selected oral and injectable specialty drugs.

» Some specialty drugs are covered under the medical benefit.

» Coverage for diabetic insulin and supplies.

REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES

» Coverage for physical therapy, occupational therapy, and speech therapy, up to combined 20 days in plan year (rehabilitative and habilitative).

» Coverage for inpatient skilled nursing and rehabilitation, up to a combined 30 days in plan year.

LIMITATIONS AND EXCLUSIONS:

» No coverage for residential/ group home treatment.

» Limitations on medical equipment within certain time periods (example: electric wheelchairs in 5 year period).

» No prosthetics other than breast and eye.

LABORATORY » ELIGIBLE EXPENSES

» Cover all medically necessary laboratory tests.

» Cover genetic tests that will change treatment.

PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT » ELIGIBLE EXPENSES

» Coverage of PPACA required preventive services.

» Wellness plan that covers biometric testing.

» Benefits include PEHP Integrated Care (case management and disease management).

PEDIATRIC ORAL AND VISION CARE » ELIGIBLE EXPENSES

» Coverage for pediatric dental services for exams, x-rays, cleanings, and sealants.

» Pediatric vision includes office visit/exam and one set of corrective lenses per year.

PEHP