Healthy Preferred
HEALTH PLANS
UNIVERSITY OF UTAH

EPO $750 85/15 Copay

	BENEFIT SCHEDULE **IN-NETWORK** *You are responsible to pay the amounts shown below*
CONDITIONS AND LIMITATIONS	
Lifetime Maximum Plan Payment	None
Pre-Existing Conditions	None
Benefit Accrual Period	Calendar Year
MEDICAL DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM	**IN-NETWORK**
Deductible – *Per Person/Family (per year)* *Included in OOP Maximum* *Does not apply to the first $1,000 of accidental injury expense*	$750/$1,500
Total Out-of-Pocket Maximum – *Per Person/Family (per year)*	$4,000/$8,000
INPATIENT SERVICES – PREAUTHORIZATION REQUIRED	**IN-NETWORK**
Inpatient Hospital, Surgical or Medical	15% After Deductible
Maternity Physician Services	15% After Deductible
Skilled Nursing Facility/Rehab Facility – *60 days combined/yr*	15% After Deductible
Hospice Facility	15% After Deductible
Mental Health or Substance Abuse Facility	15% After Deductible
OUTPATIENT SERVICES	**IN-NETWORK**
Office Visits	
Primary Care Provider (PCP)	15% After Deductible
Specialist	15% After Deductible
After Hours or Urgent Care Clinic	15% After Deductible
Mental Health or Substance Abuse	15% After Deductible
Rehabilitation or Habilitation Services	
Physical, Occupational, Aquatic and Speech Therapy limited to 36 days combined	15% After Deductible
Neurodevelopmental Therapy – limited to 40 days, and children 0-6 years	15% After Deductible
Outpatient Surgical Services	15% After Deductible
Minor Diagnostic Tests	15% After Deductible
Major Diagnostic Services	15% After Deductible
Allergy Treatment and Serum	15% After Deductible
Other Medical Services Performed at an Outpatient Facility	15% After Deductible
PREVENTIVE SERVICES	**IN-NETWORK**
Primary Care Provider (PCP)	Covered at 100%
Specialist	Covered at 100%
Vision Exam	Covered at 100%
Adult and Pediatric Immunizations	Covered at 100%
Elective Immunizations *(herpes zoster (shingles), rotavirus)*	Covered at 100%
Minor Diagnostic Tests	Covered at 100%
Other Preventive Services	Covered at 100%
EMERGENCY SERVICES	**IN-NETWORK AND OUT-OF-NETWORK**
Emergency Room – *Waived if admitted to the hospital*	$150 Copay + 15% After Deductible
Ambulance (Air or Ground) – *Emergencies Only*	15% After Deductible
HOME HEALTH CARE SERVICES AND SUPPLIES – PREAUTHORIZATION MAY BE REQUIRED	**IN-NETWORK**
Hospice Care Provided at Home	15% After Deductible
Home Health Care – *Up to 130 visits per year*	15% After Deductible
Durable Medical Equipment (DME)	15% After Deductible
Medical Supplies	15% After Deductible

	BENEFIT SCHEDULE **IN-NETWORK** *You are responsible to pay the amounts shown below*
OTHER BENEFITS – PREAUTHORIZATION MAY BE REQUIRED	**IN-NETWORK**
Chiropractic Services – *Up to 12 visits per year*	15% After Deductible
Acupuncture – *Up to 12 visits per year*	15% After Deductible
Prenatal and Postnatal Care	
Routine Office Visits (including routine labs and screenings)	Covered at 100%
All Other Services (includes ultrasounds)	15% After Deductible
Injectable Drugs and Specialty Medications	15% After Deductible
Cochlear Implants	15% After Deductible
Temporomandibular Joint (TMJ) Services	15% After Deductible
Applied Behavior Analysis Therapy for Autism – *600 hrs/year*	15% After Deductible
PRESCRIPTION BENEFITS (Administered by ProCare Rx) – PREAUTHORIZATION MAY BE REQUIRED	**IN-NETWORK**
Prescription Drugs – *Up to 30 Day Supply of Covered Medication*	ARUP Preferred / Retail
Tier 0 (Preventive Drugs)	Covered at 100%
Tier 1 (Preferred Generic Drugs)	$5 Copay / $15 Copay
Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)	$30 Copay / $50 Copay
Tier 3 (Non-Preferred Brand Drugs)	35% up to $145 / 35% up to $150
Tier 4 (Preferred Specialty Drugs) – *must be filled through University or Utah Specialty Pharmacy or ProCare Rx Specialty Pharmacy*	35%
Mail Order – *90 Day Supply – selected drugs*	
Tier 0 (Preventive Drugs)	Covered at 100%
Tier 1 (Preferred Generic Drugs)	$45
Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)	$150
Tier 3 (Non-Preferred Brand Drugs)	35% up to $450
Tier 4 (Preferred Specialty Drugs)	Not Available
*Generic required or must pay copay/coinsurance plus cost difference between brand name and generic	

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.
-Primary Care Physicians are those with a primary specialty of General Medicine, Family Medicine, Internal Medicine, Pediatrics, and OB/Gyn.
-Frequency and/or quantity limitations apply to some preventive care and medical supplies.
-All covered services obtained outside the United States, except for urgent or emergency conditions, will be paid at the Out-of-Network benefit.
-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 (801) 587-6480 or (888) 271-5870 from 8:00 am to 6:00 pm, Monday – Friday. In-Network benefits will be applied to all Utah providers within the Healthy Preferred Network. All Healthy Preferred benefits are administered by University of Utah Health Plans. This plan is not available to employees living outside the state of Utah.

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