HealthyPremier

HEALTH PLANS
UNIVERSITY OF UTAH

ARUP Effective Date January 1, 2020

# PPO $1500 85/15 Copay

| | BENEFIT SCHEDULE | |
|---|---|---|
| | **IN-NETWORK** *You are responsible to pay the amounts shown below* | **OUT-OF-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** | **OUT-OF-NETWORK** |
| Deductible – *Per Person/Family (per year)* | $1,500/$3,000 | |
| *Included in OOP Maximum* | | |
| *Does not apply to the first $1,000 of accidental injury expense* | | |
| Total Out-of-Pocket Maximum – *Per Person/Family (per year)* | $4,000/$8,000 | |
| **INPATIENT SERVICES – PREAUTHORIZATION IS REQUIRED** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| Inpatient Hospital, Surgical or Medical | 15% After Deductible | 35% After Deductible |
| Maternity Physician Services | 15% After Deductible | 35% After Deductible |
| Skilled Nursing Facility/Rehab Facility (based upon medical necessity) | 15% After Deductible | 35% After Deductible |
| Hospice Facility | 15% After Deductible | 35% After Deductible |
| Mental Health or Substance Abuse Facility | 15% After Deductible | 35% After Deductible |
| **OUTPATIENT SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| Office Visits | | |
| Primary Care Provider (PCP) | 15% After Deductible | 35% After Deductible |
| Specialist | 15% After Deductible | 35% After Deductible |
| After Hours or Urgent Care Clinic | 15% After Deductible | 35% After Deductible |
| Mental Health or Substance Abuse | 15% After Deductible | 35% After Deductible |
| Rehabilitation or Habilitation Services | 15% After Deductible | 35% After Deductible |
| *Physical, Occupational, Aquatic and Speech Therapy (Based upon medical necessity)* | 15% After Deductible | 35% After Deductible |
| *Neurodevelopmental Therapy (Based upon medical necessity)* | 15% After Deductible | 35% After Deductible |
| Outpatient Surgical Services | 15% After Deductible | 35% After Deductible |
| Minor Diagnostic Tests | 15% After Deductible | 35% After Deductible |
| Major Diagnostic Services | 15% After Deductible | 35% After Deductible |
| Allergy Treatment and Serum | 15% After Deductible | 35% After Deductible |
| Other Medical Services Performed at an Outpatient Facility | 15% After Deductible | 35% After Deductible |
| **PREVENTIVE SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| Primary Care Provider (PCP) | Covered at 100% | 35% After Deductible |
| Specialist | Covered at 100% | 35% After Deductible |
| Vision Exam | Covered at 100% | 35% After Deductible |
| Adult and Pediatric Immunizations | Covered at 100% | 35% After Deductible |
| Elective Immunizations *(herpes zoster (shingles), rotavirus)* | Covered at 100% | 35% After Deductible |
| Minor Diagnostic Tests | Covered at 100% | 35% After Deductible |
| Other Preventive Services | Covered at 100% | 35% After Deductible |
| **EMERGENCY SERVICES** | | |
| Emergency Room – *Waived if admitted to the hospital* | $250 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** | **OUT-OF-NETWORK** |
| Hospice Care Provided at Home | 15% After Deductible | 35% After Deductible |
| Home Health Care *(based upon medical necessity)* | 15% After Deductible | 35% After Deductible |
| Durable Medical Equipment (DME) | 15% After Deductible | 35% After Deductible |
| Medical Supplies | 15% After Deductible | 35% After Deductible |

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| **OTHER BENEFITS – PREAUTHORIZATION MAY BE REQUIRED** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| Chiropractic Services - 12 visits per calendar year | 15% After Deductible | 35% After Deductible |
| Acupuncture - 12 visits per calendar year | 15% After Deductible | 35% After Deductible |
| Prenatal and Postnatal Care | | |
| Routine Office Visits (including routine labs and screenings) | Covered at 100% | 35% After Deductible |
| All Other Services (includes ultrasounds) | 15% After Deductible | 35% After Deductible |
| Injectable Drugs and Specialty Medications | 15% After Deductible | 35% After Deductible |
| Cochlear Implants | 15% After Deductible | 35% After Deductible |
| Temporomandibular Joint (TMJ) Services | 15% After Deductible | 35% After Deductible |

**PRESCRIPTION BENEFITS (Administered by Navitus Rx) – PREAUTHORIZATION MAY BE REQUIRED**

**OUT-OF-NETWORK**

**No Out-of-Network Benefits for Pharmacy**

**Copayment per Prescription**

| Drug Type | Retail PBM Network | Mail Order | Specialty Drug |
|---|---|---|---|
| Tier 1 | $5 1-30 day supply<br>$10 31-60 day supply<br>$15 61-90 day supply | $5 1-30 day supply<br>$10 31-60 day supply<br>$12.50 61-90 day supply | 35% ($145 max)<br>1-30 day supply |
| Tier 2 | $30 1-30 day supply<br>$60 31-60 day supply<br>$90 61-90 day supply | $30 1-30 day supply<br>$60 31-60 day supply<br>$75 61-90 day supply | 35% ($145 max)<br>1-30 day supply |
| Tier 3 | 35% ($145 max)<br>1-30 day supply<br>35% ($290 max)<br>31-60 day supply<br>35% ($435 max)<br>61-90 day supply | 35% ($145 max)<br>1-30 day supply<br>35% ($290 max)<br>31-60 day supply<br>35% ($375 max)<br>61-90 day supply | 35% ($145 max)<br>1-30 day supply |
| Compound Medications | 35% ($145 max) | No Benefit | No Benefit |

**Copayment per Prescription for Maintenance Therapy Drugs**

| Drug Type | 1-30 Day Supply | 31-60 Day Supply | 61-90 Day Supply |
|---|---|---|---|
| Tier 1 | $5 | $10 | $12.50 |
| Tier 2 | $30 | $60 | $75 |
| Tier 3 | 35% ($145 Max) | 35% ($290 Max) | 35% ($375 Max) |

***Maintenance Therapy Drugs: Prescriptions may be obtained for Maintenance Therapy Drugs, subject to the applicable Copayment as stated above. A complete list of Maintenance Therapy Drugs may be obtained from the Pharmacy Benefit Manager. The Maintenance Therapy Drug list may also be referred to as "Preventive Therapy Drug List" by the Pharmacy Benefit Manager. Generic diabetic products, preferred insulin products and drugs covered under the Affordable Care Act (ACA) are not covered under this benefit.***
***Please refer to the Summary Plan Description for more detailed information for your pharmacy benefits.***

*-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.*

*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.*

*For more information, please call Customer Service at (801) 213-4008 or (833) 981-0213 from 8:00 am to 6:00 pm, Monday – Friday. In-Network benefits will be applied to all Utah providers within the Healthy Premier Network and all out of state providers in the FirstHealth Network. All Healthy Premier benefits are administered by University of Utah Health Plans.*