6053 Fashion Square Dr. Suite 110
Murray, UT 84107

ARUP Healthy Preferred EPO $750-$4000-15% Package

Schedule of Benefits

HEALTH PLANS
UNIVERSITY OF UTAH

HEALTHYPREFERRED

Plan Name: ARUP Healthy Preferred EPO $750-$4000-15% Package
Employer Name: ARUP Laboratories
Effective Period: From 01/01/2021 through 12/31/2021
Benefit Accrual Period: Calendar Year

Medical Care Deductible and Out of Pocket Maximum (OOPM)		
General Cost Share & Features	**In-Network**	**Out-of-Network**
Deductible: - Medical and Drug Combined. *- Does not apply to the first $1,000 of accidental injury expense*	$750 – self only; $750/$1,500 – per person/family	Not Covered
Out-of-Pocket Maximum:	$4,000 – self only; $4,000/$8,000 – per person/family	Not Covered

Benefit	In-Network	Out-of-Network
INPATIENT SERVICES*		
Inpatient Hospital, Surgical or Medical	15% after Deductible	Not Covered
Maternity Physician Services	15% after Deductible	Not Covered
Skilled Nursing Facility/Acute Rehab (Unlimited - Based on Medical Necessity)	15% after Deductible	Not Covered
Long Term Acute Care	15% after Deductible	Not Covered
Hospice Care	15% after Deductible	Not Covered
Mental Health or Substance Abuse Facility	15% after Deductible	Not Covered
Residential Treatment Facility	15% after Deductible	Not Covered
OUTPATIENT SERVICES*		
Primary Care Provider (PCP) Office Visits	15% after Deductible	Not Covered
Specialist Office Visits	15% after Deductible	Not Covered
After Hours or Urgent Care Clinic (Service area includes Salt Lake, Davis, Weber, and Utah Counties)	15% after Deductible	**Within Coverage Area:** Not Covered **Outside Coverage Area:** 15% after In Network Deductible
Mental Health or Substance Abuse Office Visit	15% after Deductible	Not Covered
Rehabilitation or Habilitation Services (Unlimited - Based on Medical Necessity) *Includes physical, occupations, aquatic, and speech therapy*	15% after Deductible	Not Covered
Outpatient Surgical Services	15% after Deductible	Not Covered
Other Medical Services Performed at an Outpatient Facility	15% after Deductible	Not Covered
Allergy Treatment and Serum	15% after Deductible	Not Covered
Major Diagnostic Services	15% after Deductible	Not Covered
Minor Diagnostic Services	15% after Deductible	Not Covered

Benefit	In-Network	Out-of-Network
Emergency Room - Copay Waived if admitted to the hospital	$250, then 15% after Deductible	$250, then 15% after Deductible
Ambulance (Air or Ground) - Emergencies Only	**Ambulance - Ground:** 15% after Deductible **Ambulance - Air:** 15% after Deductible	**Ambulance - Ground:** 15% after Deductible **Ambulance - Air:** 15% after Deductible
PREVENTIVE SERVICES		
Primary Care Provider (PCP)	No Charge	Not Covered
Specialist	No Charge	Not Covered
Eye Exam (Limited to 1 Visit per calendar year)	No Charge	Not Covered
Adult and Pediatric Immunizations	No Charge	Not Covered
Elective Immunizations (herpes zoster (shingles), rotavirus)*	No Charge	Not Covered
Minor Diagnostic Services	No Charge	Not Covered
Other Preventive Services	No Charge	Not Covered
OTHER BENEFITS*		
Durable Medical Equipment (DME) (Prior Authorization required for any device over $5,000)	15% after Deductible	Not Covered
Injectable Drugs and Specialty Medications	15% after Deductible	Not Covered
Hospice Care Provided at Home	15% after Deductible	Not Covered
Home Health Care (Unlimited - Based on Medical Necessity)	15% after Deductible	Not Covered
Chiropractic Services (Limited to 12 Visits per calendar year)	15% after Deductible	Not Covered
Cochlear Implants	15% after Deductible	Not Covered
Temporomandibular Joint (TMJ) Services (Limited to $5,000 per lifetime)	15% after Deductible	Not Covered
Medical Supplies	15% after Deductible	Not Covered

Prescription Benefits*

Benefits administered through Navitus Rx

RETAIL PHARMACY		
Benefit	**In-Network**	**Out-of-Network**
Tier 0 (ACA Preventive Drugs)	No Charge	Not Covered
Tier 1	1-30 Days: $5, Deductible Does Not Apply 31-60 Days: $10, Deductible Does Not Apply 61-90 Days: $15, Deductible Does Not Apply	Not Covered
Tier 2	1-30 Days: $30, Deductible Does Not Apply 31-60 Days: $60, Deductible Does Not Apply 61-90 Days: $90, Deductible Does Not Apply	Not Covered
Tier 3	1-30 Days: 35%, Deductible Does Not Apply (Up to $145 max) 31-60 Days: 35%, Deductible Does Not Apply (Up to $290 max) 61-90 Days: 35%, Deductible Does Not Apply (Up to $435 max)	Not Covered
Specialty Drugs	1-30 Days: 35%, Deductible Does Not Apply (Up to $145 max)	Not Covered
Compound Medications	35%, Deductible Does Not Apply (Up to $145 max)	Not Covered

MAIL ORDER Pharmacy* – SELECTED DRUGS**		
Benefit	**In-Network**	**Out-of-Network**
Tier 0 (ACA Preventive Drugs)	No Charge	Not Covered
Tier 1	1-30 Days: $5, Deductible Does Not Apply 31-60 Days: $10, Deductible Does Not Apply 61-90 Days: $12.50, Deductible Does Not Apply	Not Covered
Tier 2	1-30 Days: $30, Deductible Does Not Apply 31-60 Days: $60, Deductible Does Not Apply 61-90 Days: $75, Deductible Does Not Apply	Not Covered
Tier 3	1-30 Days: 35%, Deductible Does Not Apply (Up to $145 max) 31-60 Days: 35%, Deductible Does Not Apply (Up to $290 max) 61-90 Days: 35%, Deductible Does Not Apply (Up to $375 max)	Not Covered
Specialty Drugs	Not Covered	Not Covered
Compound Medications	Not Covered	Not Covered

Maintenance Therapy Drugs – Retail**		
Benefit	**In-Network**	**Out-of-Network**
Tier 1	1-30 Days: $5, Deductible Does Not Apply 31-60 Days: $10, Deductible Does Not Apply 61-90 Days: $12.50, Deductible Does Not Apply	Not Covered
Tier 2	1-30 Days: $30, Deductible Does Not Apply 31-60 Days: $60, Deductible Does Not Apply 61-90 Days: $75, Deductible Does Not Apply	Not Covered
Tier 3	1-30 Days: 35%, Deductible Does Not Apply (Up to $145 max) 31-60 Days: 35%, Deductible Does Not Apply (Up to $290 max) 61-90 Days: 35%, Deductible Does Not Apply (Up to $375 max)	Not Covered

Notice/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.
** Maintenance Therapy Drugs: Prescriptions may be obtained for Maintenance Therapy Drugs, subject to applicable Copayment as stated above. A completed list of Maintenance Therapy Drugs may be obtained from the Pharmacy Benefit Manager. The 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.

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 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 Preferred Network and all out of state providers in the First Health Emergencies Only Network. All Healthy Preferred benefits are administered by University of Utah Health Plans.