

LEVEL FUNDED - 01/01/2020

BENEFIT SCHEDULE



HEALTHY PREFERRED EPO \$1000-\$4000-20%

IN-NETWORK

OUT-OF-NETWORK

You are responsible to pay the amounts shown below

CONDITIONS, LIMITATIONS, DEDUCTIBLE, OUT OF POCKET MAXIMUM

| | | |
|---|-----------------|-------------|
| Benefit Accrual Period | Calendar Year | Not Covered |
| Pre-Existing Conditions | None | None |
| Lifetime Maximum Plan Payment | None | None |
| Maximum Annual Out of Network Payment (per benefit year) | None | None |
| Self Only Coverage Deductible | \$1,000 | Not Covered |
| Self Only Coverage Out of Pocket Maximum | \$4,000 | Not Covered |
| Family Coverage Deductible - per Person/Family | \$1,000/\$2,000 | Not Covered |
| Family Coverage Out of Pocket Maximum - per Person/Family | \$4,000/\$8,000 | Not Covered |

INPATIENT SERVICES *

| | | |
|---|--------|-------------|
| Inpatient Hospital, Surgical or Medical | 20% AD | Not Covered |
| Maternity Physician Services | 20% AD | Not Covered |
| Skilled Nursing Facility/Rehab Facility – 60 days combined/yr | 20% AD | Not Covered |
| Hospice Facility | 20% AD | Not Covered |
| Mental Health or Substance Abuse Facility | 20% AD | Not Covered |

OUTPATIENT SERVICES

| | | |
|---|-----------------|----------------|
| Virtual Visits | Covered at 100% | Not Covered |
| Primary Care Provider (PCP) Office Visits | \$0 Copay | Not Covered |
| Specialist Office Visits | \$75 Copay | Not Covered |
| After Hours or Urgent Care Clinic | \$75 Copay | Not Covered |
| Mental Health or Substance Abuse Office Visit | \$0 Copay | Not Covered |
| Rehabilitation or Habilitation Services - 40 days combined/yr | \$75 Copay | Not Covered |
| Outpatient Surgical Services | 20% AD | Not Covered |
| Other Medical Services Performed at an Outpatient Facility | 20% AD | Not Covered |
| Allergy Treatment and Serum | 20% AD | Not Covered |
| Major Diagnostic Services | 20% AD | Not Covered |
| Minor Diagnostic Services | Covered at 100% | Not Covered |
| Emergency Room – Waived if admitted to the hospital | \$300 Copay AD | \$300 Copay AD |
| Ambulance (Air or Ground) – Emergencies Only | 20% AD | 20% AD |

PREVENTIVE SERVICES

| | | |
|--|-----------------|-------------|
| Primary Care Provider (PCP) | Covered at 100% | Not Covered |
| Specialist | Covered at 100% | Not Covered |
| Eye Exam – Limit 1 per person per year | Covered at 100% | Not Covered |
| Adult and Pediatric Immunizations | Covered at 100% | Not Covered |
| Elective Immunizations (herpes zoster (shingles), rotavirus) | Covered at 100% | Not Covered |
| Minor Diagnostic Services | Covered at 100% | Not Covered |
| Other Preventive Services | Covered at 100% | Not Covered |

OTHER BENEFITS *

| | | |
|--|--|-------------|
| Chiropractic Services – Up to 12 visits per year | \$75 Copay | Not Covered |
| Injectable Drugs and Specialty Medications | 20% AD | Not Covered |
| Hospice Care Provided at Home | 20% AD | Not Covered |
| Home Health Care – Up to 60 visits per year | 20% AD | Not Covered |
| Durable Medical Equipment (DME) | 20% AD | Not Covered |
| Medical Supplies | 20% AD | Not Covered |
| Adoption – Must take place within 90 days of birth | Up to \$4,000 reimbursement for covered adoption expenses after deductible has been met. | |



You are responsible to pay the amounts shown below

PRESCRIPTION BENEFITS * ^

| | IN-NETWORK | OUT-OF-NETWORK |
|---|-----------------|----------------|
| Retail Pharmacy (Up to 30 Day Supply) | | |
| Tier 0 (Preventive Drugs) | Covered at 100% | Not Covered |
| Tier 1 (Preferred Generic Drugs) | \$10 Copay | Not Covered |
| Tier 2 (Preferred Brand and Non-Preferred Generic Drugs) | \$30 Copay | Not Covered |
| Tier 3 (Non-Preferred Brand Drugs) | \$70 Copay | Not Covered |
| Tier 4 (Preferred Specialty Drugs) ± | \$100 Copay | Not Covered |
| Mail Order Pharmacy ±± (up to 90 Day Supply – Selected Drugs) | | |
| Tier 0 (Preventive Drugs) | Covered at 100% | Not Covered |
| Tier 1 (Preferred Generic Drugs) | \$20 Copay | Not Covered |
| Tier 2 (Preferred Brand and Non-Preferred Generic Drugs) | \$60 Copay | Not Covered |
| Tier 3 (Non-Preferred Brand Drugs) | \$210 Copay | Not Covered |
| Tier 4 (Preferred Specialty Drugs) | Not Available | Not Covered |

* Preauthorization may be required.

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

± 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

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

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 (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. All Healthy PREFERRED benefits are administered by University of Utah Health Plans.