LEVEL FUNDED - 01/01/2020	BENEFIT SCHEDULE	
	IN-NETWORK	OUT-OF-NETWORK
HEALTHY PREFERRED EPO $1500-$3000-20% QHDHP	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	$1,500	Not Covered
Self Only Coverage Out of Pocket Maximum	$3,000	Not Covered
Family Coverage Deductible - per Person/Family	$3,000	Not Covered
Family Coverage Out of Pocket Maximum - per Person/Family	$6,000	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	0% AD	Not Covered
Primary Care Provider (PCP) Office Visits	20% AD	Not Covered
Specialist Office Visits	20% AD	Not Covered
After Hours or Urgent Care Clinic	20% AD	Not Covered
Mental Health or Substance Abuse Office Visit	20% AD	Not Covered
Rehabilitation or Habilitation Services - 40 days combined/yr	20% AD	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	0% AD	Not Covered
Emergency Room – Waived if admitted to the hospital	20% AD	20% 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	20% AD	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.	

SIGN ____________________

LEVEL FUNDED - 01/01/2020

HEALTHY PREFERRED EPO $1500-$3000-20% QHDHP

PRESCRIPTION BENEFITS * ^	IN-NETWORK	OUT-OF-NETWORK
BENEFIT SCHEDULE	You are responsible to pay the amounts shown below	
Retail Pharmacy (Up to 30 Day Supply)		
Tier 0 (Preventive Drugs)	Covered at 100%	Not Covered
Tier 1 (Preferred Generic Drugs)	20% AD	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)	20% AD	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	20% AD	Not Covered
Tier 4 (Preferred Specialty Drugs) ±	20% AD	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% AD	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)	20% AD	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	20% AD	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.

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