LEVEL FUNDED - 01/01/2020	BENEFIT SCHEDULE	
HEALTH PLANS UNIVERSITY OF UTAH	IN-NETWORK	OUT-OF-NETWORK
HEALTHY PREMIER PPO $1000-$4000-20%	You are responsible to pay the amounts shown below	
CONDITIONS, LIMITATIONS, DEDUCTIBLE, OUT OF POCKET MAXIMUM		
Benefit Accrual Period	Calendar Year	Calendar Year
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	$5,000
Self Only Coverage Out of Pocket Maximum	$4,000	$10,000
Family Coverage Deductible - per Person/Family	$1,000/$2,000	$5,000/$10,000
Family Coverage Out of Pocket Maximum - per Person/Family	$4,000/$8,000	$10,000/$20,000
INPATIENT SERVICES *		
Inpatient Hospital, Surgical or Medical	20% AD	50% AD
Maternity Physician Services	20% AD	50% AD
Skilled Nursing Facility/Rehab Facility – 60 days combined/yr	20% AD	50% AD
Hospice Facility	20% AD	50% AD
Mental Health or Substance Abuse Facility	20% AD	50% AD
OUTPATIENT SERVICES		
Virtual Visits	Covered at 100%	Not Covered
Primary Care Provider (PCP) Office Visits	$25 Copay	50% AD
Specialist Office Visits	$75 Copay	50% AD
After Hours or Urgent Care Clinic	$75 Copay	50% AD
Mental Health or Substance Abuse Office Visit	$25 Copay	50% AD
Rehabilitation or Habilitation Services - 40 days combined/yr	$75 Copay	50% AD
Outpatient Surgical Services	20% AD	50% AD
Other Medical Services Performed at an Outpatient Facility	20% AD	50% AD
Allergy Treatment and Serum	20% AD	50% AD
Major Diagnostic Services	20% AD	50% AD
Minor Diagnostic Services	Covered at 100%	50% AD
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	50% AD
Injectable Drugs and Specialty Medications	20% AD	50% AD
Hospice Care Provided at Home	20% AD	50% AD
Home Health Care – Up to 60 visits per year	20% AD	50% AD
Durable Medical Equipment (DME)	20% AD	50% AD
Medical Supplies	20% AD	50% AD
Adoption – Must take place within 90 days of birth	Up to $4,000 reimbursement for covered adoption expenses after deductible has been met.	

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LEVEL FUNDED - 01/01/2020	BENEFIT SCHEDULE	
HEALTH PLANS UNIVERSITY OF UTAH	IN-NETWORK	OUT-OF-NETWORK
HEALTHY PREMIER PPO $1000-$4000-20%	You are responsible to pay the amounts shown below	
PRESCRIPTION BENEFITS * ^		
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 PREMIER Network and all out of state providers in the FirstHealth Network. All Healthy PREMIER benefits are administered by University of Utah Health Plans.

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