LEVEL FUNDED - 01/01/2020

HEALTHY PREMIER PPO $4000-$6000- 30%EM B QHDHP

CONDITIONS, LIMITATIONS, DEDUCTIBLE, OUT OF POCKET MAXIMUM

<table>
<thead>
<tr>
<th>Benefit Accrual Period</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pre-Existing Conditions

None

Lifetime Maximum Plan Payment

None

Maximum Annual Out of Network Payment (per benefit year)

None

Self Only Coverage Deductible

$4,000

Self Only Coverage Out of Pocket Maximum

$6,000

Family Coverage Deductible - per Person/Family

$6,000

Family Coverage Out of Pocket Maximum - per Person/Family

$6,000

INPATIENT SERVICES *

- Inpatient Hospital, Surgical or Medical
  30% AD
  50% AD

- Maternity Physician Services
  30% AD
  50% AD

- Skilled Nursing Facility/Rehab Facility – 60 days combined/yr
  30% AD
  50% AD

- Hospice Facility
  30% AD
  50% AD

- Mental Health or Substance Abuse Facility
  30% AD
  50% AD

OUTPATIENT SERVICES

- Virtual Visits
  0% AD
  Not Covered

- Primary Care Provider (PCP) Office Visits
  30% AD
  50% AD

- Specialist Office Visits
  30% AD
  50% AD

- After Hours or Urgent Care Clinic
  30% AD
  50% AD

- Mental Health or Substance Abuse Office Visit
  30% AD
  50% AD

- Rehabilitation or Habilitation Services - 40 days combined/yr
  30% AD
  50% AD

- Outpatient Surgical Services
  30% AD
  50% AD

- Other Medical Services Performed at an Outpatient Facility
  30% AD
  50% AD

- Allergy Treatment and Serum
  30% AD
  50% AD

- Major Diagnostic Services
  30% AD
  50% AD

- Minor Diagnostic Services
  0% AD
  50% AD

- Emergency Room – Waived if admitted to the hospital
  30% AD
  30% AD

- Ambulance (Air or Ground) – Emergencies Only
  30% AD
  30% AD

PREVENTIVE SERVICES

- Primary Care Provider (PCP)
  Covered at 100%
  Not Covered

- Specialist
  Covered at 100%
  Not Covered

- Eye Exam – Limit 1 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
  30% AD
  50% AD

- Injectable Drugs and Specialty Medications
  30% AD
  50% AD

- Hospice Care Provided at Home
  30% AD
  50% AD

- Home Health Care – Up to 60 visits per year
  30% AD
  50% AD

- Durable Medical Equipment (DME)
  30% AD
  50% AD

- Medical Supplies
  30% 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.
LEVEL FUNDED - 01/01/2020

HEALTHY PREMIER PPO $4000-$6000- 30%EMB QHDHP

BENEFIT SCHEDULE

IN-NETWORK  OUT-OF-NETWORK

You are responsible to pay the amounts shown below

<table>
<thead>
<tr>
<th>PRESCRIPTION BENEFITS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Pharmacy (Up to 30 Day Supply)</td>
<td>Covered at 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 0 (Preventive Drugs)</td>
<td>30%AD</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 1 (Preferred Generic Drugs)</td>
<td>30%AD</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)</td>
<td>30%AD</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 3 (Non-Preferred Brand Drugs)</td>
<td>30%AD</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 4 (Preferred Specialty Drugs)</td>
<td>30%AD</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mail Order Pharmacy ±± (up to 90 Day Supply - Selected Drugs)</td>
<td>Covered at 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 0 (Preventive Drugs)</td>
<td>30%AD</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 1 (Preferred Generic Drugs)</td>
<td>30%AD</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)</td>
<td>30%AD</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 3 (Non-Preferred Brand Drugs)</td>
<td>30%AD</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 4 (Preferred Specialty Drugs)</td>
<td>Not Available</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

* 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.