

LEVEL FUNDED - 01/01/2020

BENEFIT SCHEDULE



HEALTHY PREMIER PPO \$6350-\$6350-0% EMB QHDHP

IN-NETWORK OUT-OF-NETWORK

You are responsible to pay the amounts shown below

CONDITIONS, LIMITATIONS, DEDUCTIBLE, OUT OF POCKET MAXIMUM

	Calendar Year	Calendar Year
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	\$6,350	\$10,000
Self Only Coverage Out of Pocket Maximum	\$6,350	\$20,000
Family Coverage Deductible - per Person/Family	\$6,350/\$12,700	\$10,000/\$20,000
Family Coverage Out of Pocket Maximum - per Person/Family	\$6,350/\$12,700	\$20,000/\$40,000

INPATIENT SERVICES *

Inpatient Hospital, Surgical or Medical	0% AD	50% AD
Maternity Physician Services	0% AD	50% AD
Skilled Nursing Facility/Rehab Facility – 60 days combined/yr	0% AD	50% AD
Hospice Facility	0% AD	50% AD
Mental Health or Substance Abuse Facility	0% AD	50% AD

OUTPATIENT SERVICES

Virtual Visits	0% AD	Not Covered
Primary Care Provider (PCP) Office Visits	0% AD	50% AD
Specialist Office Visits	0% AD	50% AD
After Hours or Urgent Care Clinic	0% AD	50% AD
Mental Health or Substance Abuse Office Visit	0% AD	50% AD
Rehabilitation or Habilitation Services - 40 days combined/yr	0% AD	50% AD
Outpatient Surgical Services	0% AD	50% AD
Other Medical Services Performed at an Outpatient Facility	0% AD	50% AD
Allergy Treatment and Serum	0% AD	50% AD
Major Diagnostic Services	0% AD	50% AD
Minor Diagnostic Services	0% AD	50% AD
Emergency Room – Waived if admitted to the hospital	0% AD	0% AD
Ambulance (Air or Ground) – Emergencies Only	0% AD	0% 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	0% AD	50% AD
Injectable Drugs and Specialty Medications	0% AD	50% AD
Hospice Care Provided at Home	0% AD	50% AD
Home Health Care – Up to 60 visits per year	0% AD	50% AD
Durable Medical Equipment (DME)	0% AD	50% AD
Medical Supplies	0% 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.	



IN-NETWORK

OUT-OF-NETWORK

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)	0% AD	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)	0% AD	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	0% AD	Not Covered
Tier 4 (Preferred Specialty Drugs) ±	0% 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)	0% AD	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)	0% AD	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	0% 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 PREMIER Network and all out of state providers in the FirstHealth Network. All Healthy PREMIER benefits are administered by University of Utah Health Plans.