6053 Fashion Square Dr. Suite 110
Murray, UT 84107

Utah Level Funded - Healthy Preferred $500-$3000 20% EPO

Schedule of Benefits

HEALTH PLANS
UNIVERSITY OF UTAH

HEALTHYPREMIER

Plan Name: Utah Level Funded - Healthy Preferred $500-$3000 20% EPO
Employer Name: Utah Level Funded
Effective Period: From 01/01/2021 through 12/31/2021
Benefit Accrual Period: Calendar Year

Medical Care Deductible and Out of Pocket Maximum (OOPM)		
General Cost Share & Features	**In-Network**	**Out-of-Network**
Deductible: - Medical and Drug Combined.	$500 – self only; $500/$1,000 – per person/family	$5,000 – self only; $5,000/$10,000 – per person/family
Out-of-Pocket Maximum:	$3,000 – self only; $3,000/$6,000 – per person/family	$10,000 – self only; $10,000/$20,000 – per person/family

Benefit	In-Network	Out-of-Network
INPATIENT SERVICES*		
Inpatient Hospital, Surgical or Medical	20% after Deductible	50% after Deductible
Maternity Physician Services	20% after Deductible	50% after Deductible
Skilled Nursing Facility/Acute Rehab (Limited to 60 Days per calendar year)	20% after Deductible	50% after Deductible
Long Term Acute Care	20% after Deductible	50% after Deductible
Hospice Care (Limited to 6 Months every 3 years)	20% after Deductible	50% after Deductible
Mental Health or Substance Abuse Facility	20% after Deductible	50% after Deductible
Residential Treatment Facility	20% after Deductible	50% after Deductible
OUTPATIENT SERVICES*		
Telehealth/Medical****	No Charge	Not Covered
Telehealth/Mental Health****	$25, Deductible Does Not Apply	Not Covered
Primary Care Provider (PCP) Office Visits	$25, Deductible Does Not Apply	50% after Deductible
Specialist Office Visits	$75, Deductible Does Not Apply	50% after Deductible
After Hours or Urgent Care Clinic	$75, Deductible Does Not Apply	50% after Deductible
Mental Health or Substance Abuse Office Visit	$25, Deductible Does Not Apply	50% after Deductible
Rehabilitation or Habilitation Services (Limited to 40 Visits per calendar year)	$75, Deductible Does Not Apply	50% after Deductible
Outpatient Surgical Services	20% after Deductible	50% after Deductible
Other Medical Services Performed at an Outpatient Facility	20% after Deductible	50% after Deductible
Allergy Treatment and Serum	20% after Deductible	50% after Deductible
Major Diagnostic Services	20% after Deductible	50% after Deductible
Minor Diagnostic Services	No Charge	50% after Deductible
Emergency Room - Copay Waived if admitted to the hospital	$300 after Deductible	$300 after Deductible

Benefit	In-Network	Out-of-Network
Ambulance (Air or Ground) - Emergencies Only	**Ambulance - Ground:** 20% after Deductible **Ambulance - Air:** 20% after Deductible	**Ambulance - Ground:** 20% after Deductible **Ambulance - Air:** 20% after Deductible
PREVENTIVE SERVICES		
Primary Care Provider (PCP)	No Charge	Not Covered
Specialist	No Charge	Not Covered
Eye Exam (Limited to 1 Visit per calendar year)	No Charge	Not Covered
Adult and Pediatric Immunizations	No Charge	Not Covered
Elective Immunizations (herpes zoster (shingles), rotavirus)*	No Charge	Not Covered
Minor Diagnostic Services	No Charge	Not Covered
Other Preventive Services	No Charge	Not Covered
OTHER BENEFITS*		
Durable Medical Equipment (DME) (Prior Authorization required for any device over $5,000)	20% after Deductible	50% after Deductible
Injectable Drugs and Specialty Medications	20% after Deductible	50% after Deductible
Hospice Care Provided at Home (Limited to 6 Months every 3 years)	20% after Deductible	50% after Deductible
Home Health Care (Limited to 60 Visits per calendar year)	20% after Deductible	50% after Deductible
Chiropractic Services (Limited to 12 Visits per calendar year)	$75, Deductible Does Not Apply	50% after Deductible
Medical Supplies	20% after Deductible	50% after Deductible
Adoption (Must take place within 90 days of birth)	Up to $4,000 reimbursement for covered adoption expenses after deductible has been met.	

Prescription Benefits*

RETAIL PHARMACY – UP TO 30 DAY SUPPLY		
Benefit	**In-Network**	**Out-of-Network**
Tier 0 (Preventive Drugs)	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	$10, Deductible Does Not Apply	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	$30, Deductible Does Not Apply	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	$70, Deductible Does Not Apply	Not Covered
Tier 4 (Preferred Specialty Drugs)**	$100, Deductible Does Not Apply	Not Covered

MAIL ORDER Pharmacy* - UP TO 90 DAY SUPPLY – SELECTED DRUGS**		
Benefit	**In-Network**	**Out-of-Network**
Tier 0 (Preventive Drugs)	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	$20, Deductible Does Not Apply	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	$60, Deductible Does Not Apply	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	$210, Deductible Does Not Apply	Not Covered
Tier 4 (Preferred Specialty Drugs)	Not Covered	Not Covered

Notice/Notes/Terms & Conditions:

* Preauthorization may be required. Generic medications required or member responsible for copay/coinsurance plus cost difference between brand name and generic medication.
** Specialty Drugs require Prior Authorization and must be filled through a designated Specialty Pharmacy.

*** 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 if covered.

**** If your plan has telehealth benefits listed only visits with your designated Telehealth Provider, MDLive, are eligible for the Telehealth/Medical or Telehealth/Mental Health benefit. Visits with a Primary Care Provider (PCP) or Specialist will be subject to the applicable copay, coinsurance, and/or deductible, even if the visit is electronic by phone or computer.

Deductible Included in Out of Pocket Maximum. 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 First Health Network. All Healthy Premier benefits are administered by University of Utah Health Plans.