HealthyPremier

HEALTH PLANS
UNIVERSITY OF UTAH

ARUP Effective Date January 1, 2020

PPO $1500 85/15 Copay

	BENEFIT SCHEDULE	
	IN-NETWORK *You are responsible to pay the amounts shown below*	**OUT-OF-NETWORK** *You are responsible to pay the amounts shown below*
CONDITIONS AND LIMITATIONS		
Lifetime Maximum Plan Payment	None	
Pre-Existing Conditions	None	
Benefit Accrual Period	Calendar Year	
MEDICAL DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM	**IN-NETWORK**	**OUT-OF-NETWORK**
Deductible – *Per Person/Family (per year)*	$1,500/$3,000	
Included in OOP Maximum		
Does not apply to the first $1,000 of accidental injury expense		
Total Out-of-Pocket Maximum – *Per Person/Family (per year)*	$4,000/$8,000	
INPATIENT SERVICES – PREAUTHORIZATION IS REQUIRED	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Hospital, Surgical or Medical	15% After Deductible	35% After Deductible
Maternity Physician Services	15% After Deductible	35% After Deductible
Skilled Nursing Facility/Rehab Facility (based upon medical necessity)	15% After Deductible	35% After Deductible
Hospice Facility	15% After Deductible	35% After Deductible
Mental Health or Substance Abuse Facility	15% After Deductible	35% After Deductible
OUTPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits		
Primary Care Provider (PCP)	15% After Deductible	35% After Deductible
Specialist	15% After Deductible	35% After Deductible
After Hours or Urgent Care Clinic	15% After Deductible	35% After Deductible
Mental Health or Substance Abuse	15% After Deductible	35% After Deductible
Rehabilitation or Habilitation Services	15% After Deductible	35% After Deductible
Physical, Occupational, Aquatic and Speech Therapy (Based upon medical necessity)	15% After Deductible	35% After Deductible
Neurodevelopmental Therapy (Based upon medical necessity)	15% After Deductible	35% After Deductible
Outpatient Surgical Services	15% After Deductible	35% After Deductible
Minor Diagnostic Tests	15% After Deductible	35% After Deductible
Major Diagnostic Services	15% After Deductible	35% After Deductible
Allergy Treatment and Serum	15% After Deductible	35% After Deductible
Other Medical Services Performed at an Outpatient Facility	15% After Deductible	35% After Deductible
PREVENTIVE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)	Covered at 100%	35% After Deductible
Specialist	Covered at 100%	35% After Deductible
Vision Exam	Covered at 100%	35% After Deductible
Adult and Pediatric Immunizations	Covered at 100%	35% After Deductible
Elective Immunizations *(herpes zoster (shingles), rotavirus)*	Covered at 100%	35% After Deductible
Minor Diagnostic Tests	Covered at 100%	35% After Deductible
Other Preventive Services	Covered at 100%	35% After Deductible
EMERGENCY SERVICES		
Emergency Room – *Waived if admitted to the hospital*	$250 Copay + 15% After Deductible	
Ambulance (Air or Ground) – *Emergencies Only*	15% After Deductible	
HOME HEALTH CARE SERVICES AND SUPPLIES – PREAUTHORIZATION MAY BE REQUIRED	**IN-NETWORK**	**OUT-OF-NETWORK**
Hospice Care Provided at Home	15% After Deductible	35% After Deductible
Home Health Care *(based upon medical necessity)*	15% After Deductible	35% After Deductible
Durable Medical Equipment (DME)	15% After Deductible	35% After Deductible
Medical Supplies	15% After Deductible	35% After Deductible

	BENEFIT SCHEDULE	
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OTHER BENEFITS – PREAUTHORIZATION MAY BE REQUIRED	**IN-NETWORK**	**OUT-OF-NETWORK**
Chiropractic Services - 12 visits per calendar year	15% After Deductible	35% After Deductible
Acupuncture - 12 visits per calendar year	15% After Deductible	35% After Deductible
Prenatal and Postnatal Care		
Routine Office Visits (including routine labs and screenings)	Covered at 100%	35% After Deductible
All Other Services (includes ultrasounds)	15% After Deductible	35% After Deductible
Injectable Drugs and Specialty Medications	15% After Deductible	35% After Deductible
Cochlear Implants	15% After Deductible	35% After Deductible
Temporomandibular Joint (TMJ) Services	15% After Deductible	35% After Deductible

PRESCRIPTION BENEFITS (Administered by Navitus Rx) – PREAUTHORIZATION MAY BE REQUIRED

OUT-OF-NETWORK

No Out-of-Network Benefits for Pharmacy

Copayment per Prescription

Drug Type	Retail PBM Network	Mail Order	Specialty Drug
Tier 1	$5 1-30 day supply $10 31-60 day supply $15 61-90 day supply	$5 1-30 day supply $10 31-60 day supply $12.50 61-90 day supply	35% ($145 max) 1-30 day supply
Tier 2	$30 1-30 day supply $60 31-60 day supply $90 61-90 day supply	$30 1-30 day supply $60 31-60 day supply $75 61-90 day supply	35% ($145 max) 1-30 day supply
Tier 3	35% ($145 max) 1-30 day supply 35% ($290 max) 31-60 day supply 35% ($435 max) 61-90 day supply	35% ($145 max) 1-30 day supply 35% ($290 max) 31-60 day supply 35% ($375 max) 61-90 day supply	35% ($145 max) 1-30 day supply
Compound Medications	35% ($145 max)	No Benefit	No Benefit

Copayment per Prescription for Maintenance Therapy Drugs

Drug Type	1-30 Day Supply	31-60 Day Supply	61-90 Day Supply
Tier 1	$5	$10	$12.50
Tier 2	$30	$60	$75
Tier 3	35% ($145 Max)	35% ($290 Max)	35% ($375 Max)

Maintenance Therapy Drugs: Prescriptions may be obtained for Maintenance Therapy Drugs, subject to the applicable Copayment as stated above. A complete list of Maintenance Therapy Drugs may be obtained from the Pharmacy Benefit Manager. The Maintenance Therapy Drug list may also be referred to as "Preventive Therapy Drug List" by the Pharmacy Benefit Manager. Generic diabetic products, preferred insulin products and drugs covered under the Affordable Care Act (ACA) are not covered under this benefit.
Please refer to the Summary Plan Description for more detailed information for your pharmacy benefits.

-Primary Care Physicians are those with a primary specialty of General Medicine, Family Medicine, Internal Medicine, Pediatrics, and OB/Gyn.
-Frequency and/or quantity limitations apply to some preventive care and medical supplies.
-All covered services obtained outside the United States, except for urgent or emergency conditions, will be paid at the Out-of-Network benefit.
-Certain Exclusions or preauthorization may apply for services and prescription drugs. Please refer to your policy for more information.

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.

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.