University of Utah Health Insurance Plans
6053 Fashion Square Dr. Suite 110, Murray, Utah 84107

COMPREHENSIVE MEDICAL COVERAGE

OUTLINE OF COVERAGE – HEALTHY PREFERRED SILVER COPAY LIMITED

- **Read Your Policy Carefully** – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and University of Utah Health Plans (UUHP). It is, therefore, important that you READ YOUR POLICY CAREFULLY!

- **Comprehensive Medical Coverage** – This coverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy.

- **Notice** – This Plan does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. Coverage for pediatric dental services is available for purchase on a standalone basis through the Health Insurance Marketplace. Please contact the Health Insurance Marketplace to purchase the required pediatric dental services.

	SCHEDULE OF BENEFITS
HEALTHY PREFERRED SILVER COPAY LIMITED	**IN-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
DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM	**IN-NETWORK**
Individual Deductible – *Per person per calendar year*	$3,500
Family Deductible – *Per family per calendar year*	$7,000
Individual Maximum Out-of-Pocket – *Per person per calendar year*	$8,000
Family Maximum Out-of-Pocket – *Per family per calendar year*	$16,000

INPATIENT SERVICES – *requires prior authorization*	**IN-NETWORK**
Hospital – *Medical/Surgical/Anesthesia*	40% after deductible
Physician – *Medical/Surgical/Anesthesia*	40% after deductible
Mental Health or Substance Abuse Facility	40% after deductible
Maternity Care	40% after deductible
Skilled Nursing Facility – *Up to 30 days/year*	40% after deductible
Residential Treatment Facility/Partial Hospitalization – *Up to 30 days/year*	40% after deductible
Hospice Care	40% after deductible
OUTPATIENT SERVICES	**IN-NETWORK**
Office Visit	
Preventive care/screenings/immunizations	Covered at 100%
Primary Care Provider (PCP)	$30 copay
Specialist	$75 copay
Mental Health or Substance Abuse	$30 copay
Urgent Care	$30 copay
Outpatient Surgery and Other Procedures	40% after deductible
Medical Services Performed at an Outpatient Facility	40% after deductible
Laboratory and Diagnostic Services	40% after deductible
Imaging Services	40% after deductible
Mental Health or Substance Abuse Therapy	40% after deductible
Rehabilitation or Habilitation Therapy – *Limited to 20 visits/year*	40% after deductible
EMERGENCY SERVICES	**IN-NETWORK**
Emergency Room – *Copay waived if admitted to the hospital*	$500 copay after deductible
Ground Ambulance	$250 copay after deductible
Air Ambulance	40% after deductible
MISCELLANEOUS SERVICES	**IN-NETWORK**
Durable Medical Equipment (DME)	40% after deductible
Home Health Care – *Up to 30 days per calendar year*	40% after deductible
In-Home Hospice Care	40% after deductible
Medical Supplies	40% after deductible
Dialysis Services	40% after deductible
Eye exam – *One visit per calendar year for adults and children*	Covered at 100%
Glasses – *One set of corrective lenses per year for children through age 18*	Covered at 100%
**Frames are not covered*	
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**
Individual Deductible – *Per person per calendar year*	$2,000
Family Deductible – *Per family per calendar year*	$4,000
Prescription Drugs	
Tier 1 – Preferred Generic Drugs	$15 copay
Tier 2 – Preferred Brand Drugs and Non-Preferred Generic Drugs– *may require prior authorization*	25% after deductible
Tier 3 – Non-Preferred Brand Drugs – *may require prior authorization*	50% after deductible
Tier 4 – Preferred Specialty Drugs – *requires prior authorization and must be filled at the University of Utah Specialty Pharmacy*	25% after deductible

OTHER BENEFITS	WE PAY
Adoption Indemnity Benefit	$4,000 Per Adoption

***Child must be placed for adoption within 30 days of the child's birth. If more than one newborn from a single pregnancy is adopted, only one adoption indemnity benefit is available.**

GENERAL LIMITATION AND EXCLUSIONS

- **Out-of-Network Charges** – You are responsible to pay for all charges on covered services obtained from Out-of-Network providers and facilities. These charges do not apply to your Maximum Out-of-Pocket.

- **Medical Necessity** – To qualify for benefits, covered services must be medically necessary. Medical necessity is determined by UUHP's Utilization Management team, which includes a medical director along with staff physicians.

- **Non-covered Services and Complications** – When a non-covered service is performed as part of the same operation or process as a covered service, only charges relating to the covered service will be considered. Allowed amounts may be calculated and fairly apportioned to exclude any charges related to the non-covered services.
- **Excluded Services** – Please see the Policy for a full list of excluded services.

RENEWAL

This Policy is renewable at the option of the Policyholder upon payment of the monthly premium when due or within the grace period, except in cases of material fact or fraud in connection with the coverage, Our decision to cease offering this Policy to individual Policyholders, or Our decision to cease offering coverage in the individual market. Unless either formally terminated or otherwise renegotiated, the Policy will be renewed automatically on January 1 of each year. No modification or amendment will be effective until 30 days (or longer, as required by law) after written notice has been given to the Policyholder.

PREMIUMS

Subject to the provisions of the Policy, the premiums will remain the same until the end of the term of the Policy, unless federal or state law or regulations mandate that UUHP modify benefits under the contract. Premiums are payable on the 1st day of each month.

The age categories for premiums are as follows: 0-20 years; each year from 21 to 64 years (your premium may change each year from age 21 to 64), and 65 years of age or older. If you or your dependent has a birthday that moves you/them into the next age category, rates may increase upon renewal.

HEALTH PLANS
UNIVERSITY OF UTAH