6053 Fashion Square Dr. Suite 110
Murray, UT 84107

Healthy Preferred Silver Copay - 94%

Outline of Coverage

HEALTH PLANS
UNIVERSITY OF UTAH

HEALTHYPREFERRED

- **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.

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.

6053 Fashion Square Dr. Suite 110
Murray, UT 84107

Plan Name: Healthy Preferred Silver Copay - 94%
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 only.	$0 – self only; $0/$0 – per person/family	Not Covered
Out-of-Pocket Maximum:	$1,600 – self only; $1,600/$3,200 – per person/family	Not Covered

Benefit	In-Network	Out-of-Network
INPATIENT SERVICES*		
Inpatient Hospital, Surgical or Medical	10% after Deductible	Not Covered
Maternity Physician Services	10% after Deductible	Not Covered
Skilled Nursing Facility/Acute Rehab (Limited to 30 Days per calendar year each)	10% after Deductible	Not Covered
Long Term Acute Care	10% after Deductible	Not Covered
Hospice Care (Limited to 6 Months every 3 years)	10% after Deductible	Not Covered
Mental Health or Substance Abuse Facility	10% after Deductible	Not Covered
Residential Treatment Facility	10% after Deductible	Not Covered
OUTPATIENT SERVICES*		
Telehealth/Medical	No Charge	Not Covered
Telehealth/Mental Health	$10, Deductible Does Not Apply	Not Covered
Primary Care Provider (PCP) Office Visits	$10, Deductible Does Not Apply	Not Covered
Specialist Office Visits	$20, Deductible Does Not Apply	Not Covered
After Hours or Urgent Care Clinic	$10, Deductible Does Not Apply	Not Covered
Mental Health or Substance Abuse Office Visit	$10, Deductible Does Not Apply	Not Covered
Rehabilitation or Habilitation Services (Limited to 20 Visits per calendar year)	10% after Deductible	Not Covered
Outpatient Surgical Services	10% after Deductible	Not Covered
Other Medical Services Performed at an Outpatient Facility	10% after Deductible	Not Covered
Allergy Treatment and Serum	10% after Deductible	Not Covered
Major Diagnostic Services	10% after Deductible	Not Covered
Minor Diagnostic Services	10% after Deductible	Not Covered
Emergency Room - Copay Waived if admitted to the hospital	$100 after Deductible	$100 after Deductible
Ambulance (Air or Ground) - Emergencies Only	**Ambulance - Ground:** $250 after Deductible **Ambulance - Air:** 10% after Deductible	**Ambulance - Ground:** $250 after Deductible **Ambulance - Air:** 10% after Deductible

6053 Fashion Square Dr. Suite 110
Murray, UT 84107

Benefit	In-Network	Out-of-Network
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 1000)	10% after Deductible	Not Covered
Injectable Drugs and Specialty Medications	10% after Deductible	Not Covered
Hospice Care Provided at Home (Limited to 6 Months every 3 years)	10% after Deductible	Not Covered
Home Health Care (Limited to 30 Visits per calendar year)	10% after Deductible	Not Covered
Medical Supplies	10% after Deductible	Not Covered
Glasses (One set of corrective lenses per year for children through age 18. Frames not covered.)	No Charge	Not Covered
Adoption (Must take place within 90 days of birth)	Up to $4,000 reimbursement for covered adoption expenses after deductible has been met.	

6053 Fashion Square Dr. Suite 110
Murray, UT 84107

Prescription Benefits*

General Cost Share & Features	In-Network	Out-of-Network
Deductible	$0 – self only; $0/ $0 – per person/family	Not Covered

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)	$25, Deductible Does Not Apply	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	50%, Deductible Does Not Apply	Not Covered
Tier 4 (Preferred Specialty Drugs)**	20%, 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)	$50, Deductible Does Not Apply	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	Not Covered	Not Covered
Tier 4 (Preferred Specialty Drugs)	Not Covered	Not Covered

6053 Fashion Square Dr. Suite 110
Murray, UT 84107

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.

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 801-213-4111 or 833-981-0214 from 8:00 am to 6:00 pm, Monday – Friday.

In-Network benefits will be applied to all Utah providers within the Healthy Preferred Network and all out of state providers in the First Health Emergencies Only Network. All Healthy Preferred benefits are administered by University of Utah Health Plans.