

Outline of Coverage
Healthy Premier Silver Copay



HEALTH PLANS
UNIVERSITY OF UTAH

HEALTHYPREMIER

Outline of Coverage

Plan Name: Healthy Premier Silver Copay
 Coverage Period: 01/01/2025 - 12/31/2025
 Benefit Accrual Period: Calendar Year

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 unless covered by the No Surprises Act. 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.

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	In Network	Out of Network
General Cost Share		
Deductible Self Only Coverage	\$3,000	Not Covered
Deductible Family Coverage - per Person/Family	\$3,000 / \$6,000	Not Covered
Out of Pocket Maximum Self Only Coverage	\$7,000	Not Covered
Out of Pocket Maximum Family Coverage - per Person/Family	\$7,000 / \$14,000	Not Covered
Inpatient Services *		
Inpatient Hospital, Surgical or Medical	40% AD	Not Covered
Maternity Physician Services	40% AD	Not Covered
Long Term Acute Care	40% AD	Not Covered
Hospice Care	40% AD	Not Covered
Mental Health or Substance Abuse Facility	40% AD	Not Covered
Residential Treatment Facility	40% AD	Not Covered
Skilled Nursing Facility/Acute Rehab (Limited to 30 Days per calendar year)	40% AD	Not Covered
Outpatient Services *		
Primary Care Provider (PCP) Office Visits	\$30	Not Covered
Specialist Office Visits	\$75	Not Covered
Mental Health or Substance Abuse Office Visits	\$30	Not Covered
After Hours or Urgent Care Clinic	\$30	Not Covered
Telehealth Medical ¹	No Charge	Not Covered
Telehealth Mental Health ¹	\$30	Not Covered
Outpatient Surgical Services	40% AD	Not Covered
Other Medical Services Performed at an Outpatient Facility	40% AD	Not Covered
Allergy Treatment and Serum	40% AD	Not Covered
Major Diagnostic Services	40% AD	Not Covered
Minor Diagnostic Services	40% AD	Not Covered
Physical/Occupational/Speech Therapy (Limited to 20 visits combined per calendar year)	40% AD	Not Covered
Emergency Services		
Emergency Room (Copay waived if admitted to the hospital)	\$500 AD	\$500 AD
Ambulance - Ground (Emergencies Only)	\$250 AD	\$250 AD
Ambulance - Air (Emergencies Only)	40% AD	40% AD
Preventive Services		
Primary Care Provider (PCP)	No Charge	Not Covered
Specialist	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

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Miscellaneous Services *		
Durable Medical Equipment (DME)	40% AD	Not Covered
Medical Supplies	40% AD	Not Covered
Injectable Drugs and Specialty Medications	40% AD	Not Covered
Hospice Care Provided at Home	40% AD	Not Covered
Home Health Care (Limited to 30 visits per calendar year)	40% AD	Not Covered
Prosthetic device to replace lost limb	20% AD	Not Covered
Pediatric Routine Eye Exam (Limited to 1 visit per calendar year for children through age 18)	No Charge	No Charge
Glasses (One set of corrective lenses per year for children through age 18; Frames not covered)	No Charge	No Charge
Other Benefits *		
Adoption (Must take place within 90 days of birth)	Up to \$4000 reimbursement for covered adoption expenses after deductible	
Prescription Benefits *		
Deductible (per Person/Family)	\$1,000 / \$2,000	Not Covered
Retail Pharmacy - Up to 30 day supply		
Tier 0 (Preventive Drugs)	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	\$25	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	\$40	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	45% AD	Not Covered
Tier 4 (Preferred Specialty Drugs) ³	50% AD	Not Covered
Tier 5 (Non-Preferred Specialty Drugs) ³	60% AD	Not Covered
Mail Order Pharmacy ² - Up to 90 day supply - Selected Drugs		
Tier 0 (Preventive Drugs)	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	\$50	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	\$80	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	Not Covered	Not Covered
Tier 4 (Preferred Specialty Drugs) ³	Not Covered	Not Covered
Tier 5 (Non-Preferred Specialty Drugs) ³	Not Covered	Not Covered

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Terms & Conditions

AD - After Deductible

* Preauthorization may be required. Generic medications required or member responsible for copay/coinsurance plus cost difference between brand name and generic medication.

¹ 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.

² 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.

³ Specialty Drugs require Prior Authorization and must be filled through a designated Specialty Pharmacy.

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 Network and all out of state providers in the Aetna Emergency Only Network. All benefits are administered by University of Utah Health Plans.