Outline of Coverage for Carson Tahoe Health Plus $500-$4500-20%

Group Name: Carson Tahoe Health
Coverage Period: From 01/01/2025 through 12/31/2025
Benefit Accrual Period: Calendar Year

Coverage for: Individual + Family
Plan Type: Healthy Premier PPO
HSA Eligible: No

Medical Care Deductible and Out of Pocket Maximum (OOPM)

General Cost Share & Features	CTHS	In-Network	Out-of-Network
Deductible: - Medical only.	$500 – self only; $500/$1,000 – per person/family	$1,000 – self only; $1,000/$2,000 – per person/family	$2,000 – self only; $2,000/$4,000 – per person/family
The Deductible is the amount a Covered Person must contribute towards payments of eligible medical expenses. The Out-of-Network deductible amount is the maximum deductible that will be required. CTHS, In-Network, and Out-of-Network eligible medical expenses are combined for purposes of determining the maximum calendar year deductible.			
Out-of-Pocket Maximum:	$4,500 – self only; $4,500/$9,000 – per person/family	$4,500 – self only; $4,500/$9,000 – per person/family	$9,000 – self only; $9,000/$18,000 – per person/family
The OOPM is the maximum amount a Covered Person will pay for eligible medical expenses. CTHS, In-Network, and Out-of-Network eligible medical expenses are combined for the purposes of determining the maximum calendar year OOPM.			

Benefit	CTHS	In-Network	Out-of-Network
INPATIENT SERVICES*			
Inpatient Hospital, Surgical or Medical	20% after Deductible	30% after Deductible	50% after Deductible
Maternity Physician Services	20% after Deductible	30% after Deductible	50% after Deductible
Skilled Nursing Facility/Acute Rehab/Long Term Acute Care (Limited to 120 Days per calendar year)	30% after Deductible	30% after Deductible	50% after Deductible
Hospice Care	20% after Deductible	30% after Deductible	50% after Deductible
Mental Health or Substance Abuse Facility	20% after Deductible	30% after Deductible	50% after Deductible
Residential Treatment Facility	20% after Deductible	30% after Deductible	50% after Deductible
OUTPATIENT SERVICES*			
Telehealth/Medical**** (Provided through Amwell)	Not Applicable	No Charge	Not Applicable
Primary Care Provider (PCP) Office Visits	$20, Deductible Does Not Apply	$30, Deductible Does Not Apply	50% after Deductible
Specialist Office Visits	$40, Deductible Does Not Apply	$50, Deductible Does Not Apply	50% after Deductible
After Hours or Urgent Care Clinic	$40, Deductible Does Not Apply	$50, Deductible Does Not Apply	50% after Deductible

Benefit	CTHS	In-Network	Out-of-Network
Mental Health or Substance Abuse Office Visit	$40, Deductible Does Not Apply	$50, Deductible Does Not Apply	50% after Deductible
Physical Therapy (Limited to 30 Visits per calendar year)	20% after Deductible	30% after Deductible	50% after Deductible
Occupational Therapy (Limited to 30 Visits per calendar year)	20% after Deductible	30% after Deductible	50% after Deductible
Respiratory Therapy (Limited to 30 Visits per calendar year)	20% after Deductible	30% after Deductible	50% after Deductible
Speech Therapy (Limited to 30 Visits per calendar year)	20% after Deductible	30% after Deductible	50% after Deductible
Outpatient Surgical Services	20% after Deductible	30% after Deductible	50% after Deductible
Other Medical Services Performed at an Outpatient Facility	20% after Deductible	30% after Deductible	50% after Deductible
Allergy Treatment and Serum	20% after Deductible	30% after Deductible	50% after Deductible
Major Diagnostic Services (X-ray, MRI, PET, and CT Scans)	20% after Deductible	30% after Deductible	50% after Deductible
Minor Diagnostic Services (Laboratory)	No Charge	No Charge	50% after Deductible
Emergency Room - Copay Waived if admitted to the hospital	$200, Deductible Does Not Apply	30% after Deductible	30% after Deductible
Emergency Physician and Professional Services	20% after Deductible	30% after Deductible	30% after Deductible
Ambulance (Air or Ground) - Emergencies Only	**Ambulance - Ground:** Not Applicable **Ambulance - Air:** Not Applicable	**Ambulance - Ground:** $100, Deductible Does Not Apply **Ambulance - Air:** 30% after Deductible	**Ambulance - Ground:** $100, Deductible Does Not Apply **Ambulance - Air:** 30% after Deductible
PREVENTIVE SERVICES			
Primary Care Provider (PCP)	No Charge	No Charge	50% after Deductible
Specialist	No Charge	No Charge	50% after Deductible
Adult and Pediatric Immunizations	No Charge	No Charge	50% after Deductible
Elective Immunizations (herpes zoster (shingles), rotavirus)*	No Charge	No Charge	50% after Deductible
Minor Diagnostic Services	No Charge	No Charge	50% after Deductible
Other Preventive Services	No Charge	No Charge	50% after Deductible

Benefit	CTHS	In-Network	Out-of-Network
OTHER BENEFITS*			
Durable Medical Equipment (DME)	Not Applicable	30% after Deductible	50% after Deductible
Injectable Drugs and Specialty Medications	20% after Deductible	30% after Deductible	50% after Deductible
Bariatric Surgery (Limited to 1 Treatment per Lifetime)	Not Applicable	30% after Deductible	50% after Deductible
Hospice Care Provided at Home	Not Applicable	30% after Deductible	50% after Deductible
Home Health Care (Limited to 60 Visits per calendar year)	Not Applicable	30% after Deductible	50% after Deductible
Chiropractic & Acupuncture Services (Limited to 15 Visits per calendar year)	Not Applicable	$50, Deductible Does Not Apply	50% after Deductible
Diabetic Education and Related Nutritional Counseling (Subject to CTH Program Guidelines)	No Charge	Not Applicable	Not Applicable
Nutritional Counseling (Limited to $1,000 per Calendar Year)	No Charge	$35, Deductible Does Not Apply	50% after Deductible
Temporomandibular Joint (TMJ) (Limited to $4000 per Lifetime. Does not apply to Out of Pocket Maximum)	Not Applicable	30% after Deductible	50% after Deductible
Medical Supplies	20% after Deductible	30% after Deductible	50% after Deductible

Prescription Benefits*

General Cost Share & Features	CTHS	In-Network	Out-of-Network
Deductible	$50 – per person	$50 – per person	Not Covered

RETAIL PHARMACY – UP TO 30 DAY SUPPLY			
Benefit	**CTHS**	**In-Network**	**Out-of-Network**
Tier 0 (Preventive Drugs)	No Charge	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	$15, Deductible Does Not Apply	$15, Deductible Does Not Apply	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	$30, after Deductible	$30, after Deductible	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	$60, after Deductible	$60, after Deductible	Not Covered
Tier 4 (Preferred Specialty Drugs)**	20%, after Deductible	20%, after Deductible	Not Covered
MAIL ORDER Pharmacy* - UP TO 90 DAY SUPPLY – SELECTED DRUGS**			
Benefit	**CTHS**	**In-Network**	**Out-of-Network**
Tier 0 (Preventive Drugs)	No Charge	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	$30, Deductible Does Not Apply	$30, Deductible Does Not Apply	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	$60, after Deductible	$60, after Deductible	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	Not Covered	Not Covered	Not Covered
Tier 4 (Preferred Specialty Drugs)	Not Covered	Not Covered	Not Covered
SPECIAL MAINTENANCE DRUG BENEFIT - LIMITED DRUG CATEGORIES			
Benefit	**CTHS**	**In-Network**	**Out-of-Network**
Tier 1 (Limited Preferred Generic Drugs on Special Maintenance List)	No Charge	No Charge	Not Covered

RETAIL PHARMACY – UP TO 30 DAY SUPPLY			
Benefit	**CTHS**	**In-Network**	**Out-of-Network**
Tier 2 (Limited Preferred Brand and Non-Preferred Generic on Special Maintenance List)	No Charge	No Charge	Not Covered

Note: A limited number of medications fall under the Special Maintenance Drug Benefit. This benefit allows certain Tier 1 and Tier 2 prescriptions to be covered at no cost to members, without meeting deductible and/or out of pocket maximum. Medications designated under the Special Maintenance Drug benefit will show on the preferred drug list/formulary marked with an "M" indicating Special Maintenance Drug benefit.

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, Amwell, 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 833-661-3915 or 833-661-3915 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 First Health Network. All benefits are administered by University of Utah Health Plans.