Altius Health Plans: 67427-UT PKADV 86 1000 30 M4500

Coverage Period : 01/01/2014 - 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs | **Coverage for:** EE, ES, EE/1CH, EE/CHN, FAM | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http:/altiushealthcare.com/ or by calling 1-800-377-4161

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating: Individual: Level One (L1)-$1,000, Level Two (L2) - $2,000, Level Three (L3) - $3,000 Family: L1 - $2,000, L2 - $4,000, L3 - $6,000 Non-Participating: Individual: $4,000 Family: $8,000 (AD=After Deductible)	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Participating: Individual: L1 - $3,500, L2 - $5,500, L3 - $6,350 Family: L1 - $7,000, L2 - $11,000, L3 - $12,700 Non-Participating: Individual: $9,500 Family: $19,000	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balanced billed charges and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. www.altiushealthplans.com or call 1-800-377-4161	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.

The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)

This plan may encourage you to use Participating **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Level One Participating Provider	Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	L2 - $40, L3 - $50 copay/visit	40% AD	None.
	Specialist visit	$30 copay/visit	L2 - $40 copay/visit, L3 - $50 copay/visit	40% AD	----------none----------
	Other practitioner office visit	Chiropractic care: $40 copay/visit	Chiropractic care: L2/L3 - $40 copay/visit	Chiropractic care: Not covered.	Limit 20 visits per year. Prior authorization (PA) required.
	Preventive care/ Screening/Immunization	$0 copay/visit	L2 / L3 - $0 copay/visit	40% AD	None.
If you have a test	Diagnostic test (x-ray, blood work)	0% x-ray 0% lab	L2 / L3 - 0% x-ray L2 / L3 - 0% lab	40% AD - x-ray 40% AD - lab	None.
	Imaging (CT/PET scans, MRIs)	10% AD	L2 - 20% AD, L3 - 30% AD	40% AD	PA required.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at http:/altiushealthcare.com/.	Generic drugs	See participating provider column.	Retail: $15 copay / prescription; Mail Order: $45 copay / prescription	Participating providers only	Limited to a 30-day supply / 90-day supply mail order, prior auth required for some drugs
	Preferred brand drugs	See participating provider column.	Retail: $30 copay / prescription; Mail Order: $90 copay / prescription	Participating providers only	Limited to a 30-day supply / 90-day supply mail order, prior auth required for some drugs

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Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Level One Participating Provider	Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at http:/altiushealthcare.com/.	Non-preferred brand drugs	See participating provider column.	Retail: $60 copay / prescription; Mail Order: $180 copay / prescription	Participating providers only	Limited to a 30-day supply / 90-day supply mail order, prior auth required for some drugs
	Speciality drugs	Injectable medications: Preferred: 20%, Non-Preferred 30%	Injectable medications: L2/L3 - Preferred: 20%, Non-Preferred 30%	Injectable medications: - Preferred: 40% AD, Non-Preferred 50% AD	PA required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Begins at L2	L2 - 20% AD, L3 - 30% AD	40% AD	PA required.
	Physician/surgeon fees	Begins at L2.	L2 - 20% AD, L3 - 30% AD	40% AD	PA required.
If you need immediate medical attention	Emergency room services	Begins at L2.	L2 - $250 copay/vist AD, L3 - $250 copay/vist AD	$250 copay/vist AD	When medically necessary.
	Emergency medical transportation	20% AD	L2 / L3 - 20% AD	20% AD	When medically necessary.
	Urgent care	$40 copay/visit	L2 - $50 copay/visit, L3 - $60 copay/visit	$100 copay/visit	Must meet urgent care criteria.
If you have a hospital stay	Facility fee (e.g., hospital room)	Begins at L2.	L2 - 20% AD, L3 - 30% AD	40% AD	PA required.
	Physician/surgeon fee	Begins at L2.	L2 - 20% AD, L3 - 30% AD	40% AD	PA required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	See participating provider column.	Office - specialist copay / visit; Facility - medical coinsurance AD	Office - specialist copay / visit; Facility - medical coinsurance AD	Prior authorization required.
	Mental/Behavioral health inpatient services	See participating provider column.	Medical coinsurance AD	Medical coinsurance AD	Prior authorization required.

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Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Level One Participating Provider	Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder outpatient services	See participating provider column.	Office - specialist copay / visit; Facility - medical coinsurance AD	Office - specialist copay / visit; Facility - medical coinsurance AD	Prior authorization required.
	Substance use disorder inpatient services	See participating provider column.	Medical coinsurance AD	Medical coinsurance AD	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	Begins at L2.	L2 - 20% AD, L3 - 30% AD	40% AD	None.
	Delivery and all inpatient services	Begins at L2.	L2 - 20% AD, L3 - 30% AD	40% AD	None.
If you need help recovering or have other special health needs	Home health care	10% AD	L2 - 20% AD, L3 - 30% AD	40% AD	Limit 60 visits per year. PA required.
	Rehabilitation services	Inpatient Begin at L2. Outpatient Facility: 10% AD, Office:$30 copay/visit	Inpatient L2 - 20% AD, L3 - 30% AD Outpatient Facility: L2 - 20% AD, L3 - 30% AD, Office: L2 - $40, L3 - $50 copay/visit	Inpatient - 40% AD Outpatient - 40% AD	PA required.
	Habilitation services	Facility: 10% AD, Office $30 copay/visit	L2 - 20% AD, L3 - 30% AD	40% AD	PA required.
	Skilled nursing care	10% AD	L2 - 20% AD, L3 - 30% AD	40% AD	Limit 60 days per year. PA required.
	Durable medical equipment	50% co-ins	L2 / L3 - 50% co-ins	50% co-ins	PA required.
	Hospice Service	10% AD	L2 - 20% AD, L3 - 30% AD	40% AD	PA required.
If your child needs dental or eye care	Eye exam	$30 copay/visit	L2 - $40 copay/visit, L3 - $50 copay/visit	40% AD	----------none----------

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Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Level One Participating Provider	Participating Provider	Non-Participating Provider	
If your child needs dental or eye care	Glasses	Not covered.	Not covered.	Not covered.	Excluded.
	Dental check-up	Not covered.	Not covered.	Not covered.	Excluded.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Child/Dental Check-up
- Child/Glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care
- Routine Eye Care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-377-4161. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov .

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For group health coverage subject to ERISA, you may contact 1-800-377-4161. You may also contact, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform , or your state department of insurance at Utah Insurance Department: 3110 State Office Building, Salt Lake City, Utah 84114. 801-536-3800. 800-439-2805 (Toll-Free number accessible only in Utah)..

For non-federal governmental group health plans and church plans that are group health plans, you may contact 1-800-377-4161 or your state department of

insurance at Utah Insurance Department: 3110 State Office Building, Salt Lake City, Utah 84114. 801-536-3800. 800-439-2805 (Toll-Free number accessible only in Utah)..

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. **The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-800-377-4161.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-377-4161.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-377-4161.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-377-4161.

———————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*———————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much insurance protection you might get from different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,410
- **You pay:** $130

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital Charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

You pay:

Deductibles	$0
Co-pays	$100
Coinsurance	$0
Limits or exclusions	$30
Total	**$130**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,300
- **You pay:** $2,100

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccine, other preventive	$100
Total	**$5,400**

You pay:

Deductibles	$0
Co-pays	$2,000
Coinsurance	$0
Limits or exclusions	$100
Total	**$2,100**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium** , the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance** . You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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