

Preference - (ON)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: E, ES, EE/1Ch, EE/Chn,
Fam

| Plan Type: HMO



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://altius.coventryhealthcare.com/> or by calling 1-800-377-4161.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	Participating: Ind: \$6,350; Fam: \$12,700 - does not apply to preventive care (AD = After Deductible) Non-Participating: Not covered	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Participating: Yes. Ind: \$6,350; Fam: \$12,700 Non-Participating: Not covered	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u>?	Premiums, balance-billed charges, health care this plan does not cover	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. www.altiushealthplans.com or call 1-800-377-4161	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> 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 4. See your policy or plan document for additional information about <u>excluded services</u> .

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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
		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	\$20 copay/visit AD	Not covered	Participating Providers: Deductible does not apply to the first 3 visits/year
	Specialist visit	0% coinsurance (co-ins) AD	Not covered	None.
	Other practitioner office visit	Chiropractic care: Not covered	Chiropractic care: Not covered	Chiropractic care: Excluded service
	Preventive care/ Screening/Immunization	\$0	Not covered	None.
If you have a test	Diagnostic test (x-ray, blood work)	0% co-ins AD - x-ray 0% co-ins AD - lab	Not covered - x-ray Not covered - lab	None.
	Imaging (CT/PET scans, MRIs)	\$0 AD	Not covered	Prior auth required
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at http://altius.coventryhealthcare.com/.	Generic drugs	\$0 AD	Not covered	Limited to a 31-day supply/90-day supply mail order, prior auth required for some drugs
	Preferred brand drugs	\$0 AD	Not covered	Limited to a 31-day supply/90-day supply mail order, prior auth required for some drugs
	Non-preferred brand drugs	\$0 AD	Not covered	Limited to a 31-day supply/90-day supply mail order, prior auth required for some drugs
	Specialty drugs	\$0 AD	Not covered	Limited to a 30-day supply/90-day supply mail order, coverage is available only through preferred pharmacies, 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
		Participating Provider	Non-Participating Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0 AD	Not covered	Prior auth required
	Physician/surgeon fees	\$0 AD	Not covered	Prior auth required
If you need immediate medical attention	Emergency room services	\$0 AD	\$0 AD	When medically necessary
	Emergency medical transportation	\$0 AD	\$0 AD	When medically necessary
	Urgent care	\$0 AD	\$0 AD	Must meet urgent care criteria
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 AD	Not covered	Prior auth required
	Physician/surgeon fee	\$0 AD	Not covered	Prior auth required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$0 AD	Not covered	None.
	Mental/Behavioral health inpatient services	\$0 AD	Not covered	Prior auth required
	Substance use disorder outpatient services	\$0 AD	Not covered	None.
	Substance use disorder inpatient services	\$0 AD	Not covered	Prior auth required
If you are pregnant	Prenatal and postnatal care	\$0	Not covered	None.
	Delivery and all inpatient services	\$0 AD	Not covered	None.
If you need help recovering or have other special health needs	Home health care	\$0 AD	Not covered	Prior auth required
	Rehabilitation services	Inpatient - 0% co-ins AD; Outpatient - 0% co-ins AD	Inpatient - Not covered; Outpatient - Not covered	Limited to 30 visits/year, prior auth required
	Habilitation services	\$0 AD	Not covered	Limited to 20 outpatient visits/year, prior auth required
	Skilled nursing care	\$0 AD	Not covered	Prior auth required
	Durable medical equipment	\$0 AD	Not covered	Prior auth required

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Hospice Service	\$0 AD	Not covered	Prior auth required
If your child needs dental or eye care	Eye exam	\$0	Not covered	Limited to one eye exam/year
	Glasses	\$0	Not covered	Limited to one pair lenses and frames or one set of contact lenses/year
	Dental check-up	Not covered	Not covered	Excluded service

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 <u>excluded services</u> .)		
- Acupuncture - Chiropractic Care - Hearing Aids - Non-Emergency Care when Traveling Outside the U.S. - Routine Foot Care	- Bariatric Surgery - Cosmetic Surgery - Infertility Treatment - Private-Duty Nursing - Weight Loss Programs	- Child/Dental Check-up - Dental Care (Adult) - Long-Term Care - Routine Eye Care (Adult)

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.)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-377-4161. You may also contact your state insurance department at Utah Insurance Department 3110 State Office Building Salt Lake City, UT 84114 801-538-3800 800-439-3805 (Toll Free – Accessible in UT only).

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

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about your rights, this notice, or assistance, you can contact:

Utah Insurance Department 3110 State Office Building Salt Lake City, UT 84114 801-538-3800 800-439-3805 (Toll Free – Accessible in UT only)

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 (Español): Para obtener asistencia en Español, 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): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-377-4161.

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

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: \$1,110

■ You pay: \$6,430

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	\$6,400
Co-pays	\$0
Coinsurance	\$0
Limits or exclusions	\$30
Total	\$6,430

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

■ Amount owed to providers: \$5,400

■ Plan pays: \$100

■ You pay: \$5,300

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	\$5,200
Co-pays	\$0
Coinsurance	\$0
Limits or exclusions	\$100
Total	\$5,300

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.