

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

Coverage for: E, 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://altius.coventryhealthcare.com/> or by calling 1-800-377-4161.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Participating: Ind: \$1,750; Fam: \$3,500 - does not apply to PCP office visits, preventive care, urgent care Out-of-Network: Ind: \$6,400; Fam: \$12,800 (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, pharmacy deductible: \$250/Individual. There are no other specific deductibles. (APD = after pharmacy deductible)	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: Yes. Ind: \$5,000; Fam: \$10,000 Out-of-Network: No.	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, balance-billed charges, 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 <i>specific</i> 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
		Participating Provider	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$5 copay/visit	50% coinsurance (co-ins) AD	None.
	Specialist visit	\$50 copay/visit AD	50% co-ins AD	Participating Providers: Deductible does not apply to the first 5 visits/year
	Other practitioner office visit	Chiropractic care: Not covered	Chiropractic care: Not covered	Chiropractic care: Excluded service
	Preventive care/ Screening/Immunization	\$0	50% co-ins AD	None.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins AD - x-ray 20% co-ins AD - lab	50% co-ins AD - x-ray 50% co-ins AD - lab	None.
	Imaging (CT/PET scans, MRIs)	20% co-ins AD	50% co-ins AD; Outpatient: \$250 copay/visit plus 50% co-ins AD	Prior auth required
If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at http://altius.coventryhealthcare.com/ .	Generic drugs	Preferred Pharmacy: \$5; Non-Preferred Pharmacy: \$10; Mail Order: \$10	Preferred Pharmacy: \$5; Non-Preferred Pharmacy: \$10; Mail Order: \$10	Limited to a 31-day supply/90-day supply mail order, copay/prescription, prior auth required for some drugs

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at http://altius.coventryhealthcare.com/ .	Preferred brand drugs	Preferred Pharmacy: \$30 APD; Non-Preferred Pharmacy: \$40 APD; Mail Order: \$75 APD	Preferred Pharmacy: \$30 APD; Non-Preferred Pharmacy: \$40 APD; Mail Order: \$75 APD	Pharmacy deductible: \$250/Individual, limited to a 31-day supply/90-day supply mail order, copay/prescription, prior auth required for some drugs
	Non-preferred brand drugs	Preferred Pharmacy: \$60 APD; Non-Preferred Pharmacy: \$75 APD; Mail Order: \$180 APD	Preferred Pharmacy: \$60 APD; Non-Preferred Pharmacy: \$75 APD; Mail Order: \$180 APD	Pharmacy deductible: \$250/Individual, limited to a 31-day supply/90-day supply mail order, copay/prescription, prior auth required for some drugs
	Specialty drugs	Preferred Drugs: 20% co-ins APD; Non-Preferred Drugs: 30% co-ins APD	Preferred Drugs: 20% co-ins APD; Non-Preferred Drugs: 30% co-ins APD	Pharmacy deductible: \$250/Individual, limited to a 30-day supply/90-day supply mail order, coverage is available only through preferred pharmacies, prior auth required for some drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins AD	50% co-ins AD	Prior auth required
	Physician/surgeon fees	20% co-ins AD	50% co-ins AD	Prior auth required
If you need immediate medical attention	Emergency room services	\$250 copay/visit AD	\$250 copay/visit AD	Deductible does not apply to the first 3 visits/year; when medically necessary
	Emergency medical transportation	\$500 copay/occurrence	\$500 copay/occurrence	When medically necessary
	Urgent care	\$75 copay/visit	50% co-ins AD	Must meet urgent care criteria
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins AD	\$1,000 copay/admit plus 50% co-ins AD	Prior auth required
	Physician/surgeon fee	20% co-ins AD	50% co-ins AD	Prior auth required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office: \$50 copay/visit AD; Outpatient: 20% co-ins AD	50% co-ins AD	Participating Providers: Deductible does not apply to first 5 visits/year

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	20% co-ins AD	\$1,000 copay/admit plus 50% co-ins AD	Prior auth required
	Substance use disorder outpatient services	Office: \$50 copay/visit AD; Outpatient: 20% co-ins AD	50% co-ins AD	Participating Providers: Deductible does not apply to first 5 visits/year
	Substance use disorder inpatient services	20% co-ins AD	\$1,000 copay/admit plus 50% co-ins AD	Prior auth required
If you are pregnant	Prenatal and postnatal care	\$0	50% co-ins AD	None.
	Delivery and all inpatient services	Physician: \$250 copay/delivery; Facility: 20% co-ins AD	Physician: 50% co-ins AD; Facility: \$1,000 copay/admit plus 50% co-ins AD	None.
If you need help recovering or have other special health needs	Home health care	20% co-ins AD	50% co-ins AD	Limited to 30 visits/year, prior auth required
	Rehabilitation services	Inpatient - 20% co-ins AD; Outpatient - 20% co-ins AD	Inpatient - 50% co-ins AD; Outpatient - 50% co-ins AD	Limited to 30 visits/year, prior auth required
	Habilitation services	20% co-ins AD	50% co-ins AD	Limited to 20 outpatient visits/year, prior auth required
	Skilled nursing care (facility)	20% co-ins AD	50% co-ins AD	Limited to 30 days/year, prior auth required
	Durable medical equipment (including supplies)	20% co-ins AD	50% co-ins AD	None.
	Hospice Services	20% co-ins AD	50% co-ins AD	Prior auth required
If your child needs dental or eye care	Eye exam	\$0	40% co-ins plus any amount exceeding UCC	Limited to one eye exam/year; (UCC is the average participating provider reimbursement across the country for the last 12 months)

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Out-of-Network Provider	
If your child needs dental or eye care	Glasses	\$0	40% co-ins plus any amount exceeding UCC	Limited to one frame and pair of standard eyeglass lenses/year
	Dental check-up	\$0	Any amount that exceeds the out-of-network rate	Limited to two check-ups/year

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)			
• Acupuncture • Cosmetic Surgery • Infertility Treatment • Private-Duty Nursing • Weight Loss Programs	• Bariatric Surgery • Dental Care (Adult) • Long-Term Care • Routine Eye Care (Adult)	• Chiropractic Care • Hearing Aids • Non-Emergency Care when Traveling Outside the U.S. • Routine Foot Care	
Other Covered Services (This isn't a complete list. Check your policy 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 about your rights, this notice, or assistance, you can contact:

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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): Dinekehgo 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:** \$4,910

■ **You pay:** \$2,630

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	\$1,800
Co-pays	\$300
Coinsurance	\$500
Limits or exclusions	\$30
Total	\$2,630

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

■ **Amount owed to providers:** \$5,400

■ **Plan pays:** \$2,900

■ **You pay:** \$2,500

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	\$400
Co-pays	\$2,000
Coinsurance	\$0
Limits or exclusions	\$100
Total	\$2,500

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.