UTAH

Peak Plus

Benefits Summary Comparison

	Platinum			
	80%		70%	
	Par	Non-Par	Par	Non-Par
1. Calendar Year Deductible - Individual/Family *Does not apply to OOP Max. Cumulative across benefit levels*	Deductible Options[A]	2 x Par	Deductible Options[A]	2 x Par
2. Out-of-Pocket Maximum	OOP Maximum Options[B]	OOP Maximum Options[B]	OOP Maximum Options[B]	OOP Maximum Options[B]
3. Annual Benefit Maximum	Unlimited	$200,000	Unlimited	$200,000
4. Lifetime Maximum	$2 Million	$1 Million	$2 Million	$1 Million
5. Pre-Existing Condition Limitation	12 Months	12 Months	12 Months	12 Months
Outpatient Services				
6. Primary/Preventive Care (PCP)	$15	Coinsurance[C] AD	$25	Coinsurance[C] AD
7. Specialists (SPC)	2 x PCP OV Copay	Coinsurance[C] AD	2 x PCP OV Copay	Coinsurance[C] AD
8. After Hours & Urgent Care	2 x PCP OV Copay	Coinsurance[C] AD	2 x PCP OV Copay	Coinsurance[C] AD
9. Chiropractic Care – 10 visits per member per calendar year	2 x PCP OV Copay	Par Only	2 x PCP OV Copay	Par Only
10. Major Diagnostic Services	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
11. Minor Lab/X-ray (including mammograms)	You Pay Nothing	Coinsurance[C] AD	You Pay Nothing	Coinsurance[C] AD
12. Physiotherapy at Provider's Office – 10 total provider/facility visits per type, per member/calendar year	2 x PCP OV Copay	Coinsurance[C] AD	2 x PCP OV Copay	Coinsurance[C] AD
13. Physiotherapy at Facility – 10 total provider/facility visits per type, per member/calendar year	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
Emergency Care				
14. Emergency Room Care	$150	$300	$150	$300
15. Ambulance	Coinsurance[C] AD	Par Benefit Applies	Coinsurance[C] AD	Par Benefit Applies
Inpatient/Outpatient Hospital				
16. Hospitals and Surgical Centers	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
17. Physician, Surgeon, Anesthesiologist	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
18. Organ Transplant Services	Coinsurance[C] AD	Par Only	Coinsurance[C] AD	Par Only
19. Inpatient Physiotherapy Services – Limited to 30 days per member/calendar year	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
Maternity Services (Subscriber and Spouse Only)				
20. Deductible	Maternity benefits have a **Separate $7,500 Deductible** per occurrence		Maternity benefits have a **Separate $7,500 Deductible** per occurrence	
21. Prenatal and Postnatal Care	You Pay Nothing AMD	40% AMD	You Pay Nothing AMD	50% AMD
22. Inpatient Hospital/Facility Services	You Pay Nothing AMD	40% AMD	You Pay Nothing AMD	50% AMD

All Plans

- Generic Equivalent Defined: If you receive a brand name drug when a preferred generic equivalent can be substituted, you will pay the difference in cost between the generic and the brand name drug plus the generic copay/coinsurance and/or any applicable deductible. Regular benefits apply if a preferred generic cannot be substituted.
- Deductibles, Lifetime Maximums, and Out-of-Pocket Maximums are cumulative across Par and Non-Par.
- Deductibles, fixed dollar copays, and certain services DO NOT apply to the Out-of-Pocket Maximum.

This summary is for illustrative purposes only. For complete benefit disclosure, refer to the Medical Benefits Brochure in the policy or call Customer Service at 1-800-377-4161.

Benefits Summary Comparison CONT'D	Platinum 80% Par	Platinum 80% Non-Par	Platinum 70% Par	Platinum 70% Non-Par
Prescription Drugs				
23. Pharmacy Deductible (Rx)	Rx Deductible[D]	Par Only	Rx Deductible[D]	Par Only
24. Pharmacy Drugs (Rx) (Preferred Generic/Preferred Brand/Non-Preferred)	Rx Copay[E]	Par Only	Rx Copay[E]	Par Only
Injectable or Implantable Medications				
25. Injectable Meds – Non-Facility (Preferred/Non-Preferred)	20%/30%	40%/50% AD	20%/30%	40%/50% AD
26. Injectable Meds from a Pharmacy (Preferred/Non-Preferred)	20%/30%	Par Only	20%/30%	Par Only
Allergy Conditions				
27. Serum	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
28. Testing & Treatment	2 x PCP OV Copay	Coinsurance[C] AD	2 x PCP OV Copay	Coinsurance[C] AD
29. Injections	You Pay Nothing	Coinsurance[C] AD	You Pay Nothing	Coinsurance[C] AD
Other Benefits				
30. Durable Medical Equipment – $5,000 limit per member per calendar year	50%	50%	50%	50%
31. Home Health Care – 30 visits per member/calendar year	50% AD	50% AD	50% AD	50% AD
32. Hospice Care	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
33. Implantable Contraceptives and Intra-Uterine Devices (IUDs)	Coinsurance[C]	Coinsurance[C] AD	Coinsurance[C]	Coinsurance[C] AD
34. Infertility Services – Evaluation, testing, and diagnostic services; $750 per member/calendar year, up to a lifetime maximum of $5,000	50% AD	Par Only	50% AD	Par Only
35. Medical Supplies	50%	50%	50%	50%
36. Neuropsychological Testing	50% AD	50% AD	50% AD	50% AD
37. Skilled Nursing Facility – 30 days per member/calendar year	50% AD	50% AD	50% AD	50% AD
38. Sterilization Procedures – Physician's office	2 x PCP OV Copay	Coinsurance[C] AD	2 x PCP OV Copay	Coinsurance[C] AD
39. Sterilization Procedures – Outpatient facility	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
40. Temporomandibular Joint Dysfuction (TMJ) – Evaluation, testing and diagnosis services; lifetime maximum of $1,000	50% AD	50% AD	50% AD	50% AD
41. Eye Exams – Optometrist	PCP OV Copay	Coinsurance[C] AD	PCP OV Copay	Coinsurance[C] AD
Mental Health and Substance Abuse	No Coverage	No Coverage	No Coverage	No Coverage

All Plans
- Generic Equivalent Defined: If you receive a brand name drug when a preferred generic equivalent can be substituted, you will pay the difference in cost between the generic and the brand name drug plus the generic copay/coinsurance and/or any applicable deductible. Regular benefits apply if a preferred generic cannot be substituted.
- Deductibles, Lifetime Maximums, and Out-of-Pocket Maximums are cumulative across Par and Non-Par.
- Deductibles, fixed dollar copays, and certain services DO NOT apply to the Out-of-Pocket Maximum.

This summary is for illustrative purposes only. For complete benefit disclosure, refer to the Medical Benefits Brochure in the policy or call Customer Service at 1-800-377-4161.

	Gold				Silver	
	80%		70%		70%	
	Par	Non-Par	Par	Non-Par	Par	Non-Par
1.	Deductible Options[A]	2 x Par	Deductible Options[A]	2 x Par	Deductible Options[A]	2 x Par
2.	OOP Maximum Options[B]	OOP Maximum Options[B]	OOP Maximum Options[B]	OOP Maximum Options[B]	OOP Maximum Options[B]	OOP Maximum Options[B]
3.	Unlimited	$200,000	Unlimited	$200,000	Unlimited	$200,000
4.	$2 Million	$1 Million	$2 Million	$1 Million	$2 Million	$1 Million
5.	12 Months	12 Months	12 Months	12 Months	12 Months	12 Months
6.	$15	Coinsurance[C] AD	$25	Coinsurance[C] AD	$25	Coinsurance[C] AD
7.	2 x PCP OV Copay AD	Coinsurance[C] AD	2 x PCP OV Copay AD	Coinsurance[C] AD	2 x PCP OV Copay AD	Coinsurance[C] AD
8.	2 x PCP OV Copay	Coinsurance[C] AD	2 x PCP OV Copay	Coinsurance[C] AD	2 x PCP OV Copay	Coinsurance[C] AD
9.	2 x PCP OV Copay AD	Par Only	2 x PCP OV Copay AD	Par Only	2 x PCP OV Copay AD	Par Only
10.	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
11.	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
12.	2 x PCP OV Copay AD	Coinsurance[C] AD	2 x PCP OV Copay AD	Coinsurance[C] AD	2 x PCP OV Copay AD	Coinsurance[C] AD
13.	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
14.	$150 AD	$300 AD	$150 AD	$300 AD	$150 AD	$300 AD
15.	Coinsurance[C] AD	Par Benefit Applies	Coinsurance[C] AD	Par Benefit Applies	Coinsurance[C] AD	Par Benefit Applies
16.	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
17.	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
18.	Coinsurance[C] AD	Par Only	Coinsurance[C] AD	Par Only	Coinsurance[C] AD	Par Only
19.	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
20.	Maternity benefits have a **Separate $7,500 Deductible** per occurrence		Maternity benefits have a **Separate $7,500 Deductible** per occurrence		Maternity benefits have a **Separate $7,500 Deductible** per occurrence	
21.	You Pay Nothing AMD	40% AMD	You Pay Nothing AMD	50% AMD	You Pay Nothing AMD	50% AMD
22.	You Pay Nothing AMD	40% AMD	You Pay Nothing AMD	50% AMD	You Pay Nothing AMD	50% AMD

Plan Selection

☐ Platinum ☐ Gold ☐ Silver

[A]Deductible Options

Individual/Family

☐ $250/$500 *Not available on Silver*
☐ $500/$1,000 ☐ $1,000/$2,000
☐ $2,000/$4,000 ☐ $5,000/$10,000

[B]Out of Pocket Maximum Options

Linked to Coinsurance	[B]Individual/ Family Par	Individual/ Family Non-Par
80%/60% →	$2,500/$7,500 →	$3,750/$11,250
70%/50% →	$4,000/$12,000 →	$6,000/$18,000

[C]Coinsurance Options

Plan Option	[C]Coinsurance
☐ 80%/60% →	20% Par AD 40% Non-Par AD
☐ 70%/50% →	30% Par AD 50% Non-Par AD

[D, E]Pharmacy (Rx) Options

[D]Rx Deductible Options
Platinum and Gold Only

☐ $0 ☐ $250 ☐ $500 ☐ $1,000

[E]Rx Copay Options

Preferred Generic/Preferred Brand/Non-Preferred

Platinum/Gold

☐ $15/$30/50%
$60 Non-Preferred Minimum
After Pharmacy Deductible

Silver

☐ $15/$30/$60
Preferred Generic prescriptions are before medical deductible, all other prescriptions are after medical deductible.

Acronyms

- **AD**–After Deductible
- **AMD**–After Maternity Deductible
- **BD**–Before Deductible
- **Non-Par**–Non-Participating Provider Benefit
- **OOP**–Out-of-Pocket
- **OV**–Office Visit
- **Par**–Participating Provider Benefit
- **PCP**–Primary Care Physician
- **SPC**–Specialty Care Physician

	Gold				Silver	
	80%		70%		70%	
	Par	Non-Par	Par	Non-Par	Par	Non-Par
23.	Rx Deductible[D]	Par Only	Rx Deductible[D]	Par Only	N/A	N/A
24.	Rx Copay[E]	Par Only	Rx Copay[E]	Par Only	Generic BD Preferred AD/ Non-Preferred AD	Par Only
25.	20%/30%	40%/50% AD	20%/30%	40%/50% AD	20%/30%	40%/50% AD
26.	20%/30%	Par Only	20%/30%	Par Only	20%/30%	Par Only
27.	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
28.	2 x PCP OV Copay AD	Coinsurance[C] AD	2 x PCP OV Copay AD	Coinsurance[C] AD	2 x PCP OV Copay AD	Coinsurance[C] AD
29.	You Pay Nothing	Coinsurance[C] AD	You Pay Nothing	Coinsurance[C] AD	You Pay Nothing	Coinsurance[C] AD
30.	50%	50%	50%	50%	50%	50%
31.	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
32.	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
33.	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
34.	50% AD	Par Only	50% AD	Par Only	50% AD	Par Only
35.	50%	50%	50%	50%	50%	50%
36.	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
37.	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
38.	2 x PCP OV Copay AD	Coinsurance[C] AD	2 x PCP OV Copay AD	Coinsurance[C] AD	2 x PCP OV Copay AD	Coinsurance[C] AD
39.	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD	Coinsurance[C] AD
40.	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
41.	PCP OV Copay	Coinsurance[C] AD	PCP OV Copay	Coinsurance[C] AD	PCP OV Copay	Coinsurance[C] AD
	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage

Acronyms
- **AD**–After Deductible
- **AMD**–After Maternity Deductible
- **BD**–Before Deductible
- **Non-Par**–Non-Participating Provider Benefit
- **OOP**–Out-of-Pocket
- **OV**–Office Visit
- **Par**–Participating Provider Benefit
- **PCP**–Primary Care Physician
- **SPC**–Specialty Care Physician

UTAH

Peak Plus Qualified High Deductible Health Plan

Benefits Summary Comparison

Benefits Summary Comparison	QHDHP 80% Par	QHDHP 80% Non-Par	QHDHP 100% Par	QHDHP 100% Non-Par
1. Calendar Deductible – Single/Family Applies to out-of-pocket maximum	$1,500 Single / $3,000 Fam $2,000 Single /$4,000 Fam	$3,000 Single / $6,000 Fam $4,000 Single /$8,000 Fam	$3,000 Single /$6,000 Fam $5,000 Single /$10,000 Fam	$6,000 Single /$12,000 Fam $10,000 Single /$20,000 Fam
2. Out-of-Pocket Maximum – Single/Family	$5,000 Single / $10,000 Family	$10,000 Single / $20,000 Family	$3,000 Single /$6,000 Fam $5,000 Single /$10,000 Fam	$9,000 Single /$15,000 Fam $15,000 Single /$25,000 Fam
3. Annual Benefit Maximum	None	$250,000	None	$250,000
4. Lifetime Maximum*	$2 Million	$1 Million	$2 Million	$1 Million
5. Pre-Existing Condition Limitation	12 Months	12 Months	12 Months	12 Months
Outpatient Services				
6. Designated Preventive Care Services – Certain office visits and services are not subject to deductible when provided in conjunction with a preventive diagnosis as determined by Altius in accordance with Section 223 of the Internal Revenue Code.	Deductible Does Not Apply You Pay Applicable Coinsurance	40% AD	You Pay Nothing	20% AD
7. Office Visits – Primary Care	20% AD	40% AD	You Pay Nothing AD	20% AD
8. **Office Visits** – Specialists	20% AD	40% AD	You Pay Nothing AD	20% AD
9. **After Hours & Urgent Care**	20% AD	40% AD	You Pay Nothing AD	20% AD
10. **Chiropractic Care** – 10 visits per member/calendar year	20% AD	Participating Providers Only	You Pay Nothing AD	Participating Providers Only
11. **Major Diagnostic Services**	20% AD	40% AD	You Pay Nothing AD	20% AD
12. **Minor Lab/X-ray** (including mammograms)	20% AD	40% AD	You Pay Nothing AD	20% AD
13. **Physiotherapy at Provider's Office** – 10 total provider/facility visits per type, per member/calendar year	20% AD	40% AD	You Pay Nothing AD	20% AD
14. **Physiotherapy at Facility** – 10 total provider/facility visits per type, per member/calendar year	20% AD	40% AD	You Pay Nothing AD	20% AD
Emergency Care				
15. Emergency Room Care	20% AD	40% AD	You Pay Nothing AD	20% AD
16. Urgent Care	20% AD	40% AD	You Pay Nothing AD	20% AD
17. Ambulance	20% AD	Participating Benefit Applies	You Pay Nothing AD	Participating Benefit Applies
Inpatient/Outpatient Hospital				
18. Inpatient Hospital / Facility Services	20% AD	40% AD	You Pay Nothing AD	20% AD
19. Outpatient Hospital / Facility Services	20% AD	40% AD	You Pay Nothing AD	20% AD
20. Additional Professional Services – Billed by facility	20% AD	40% AD	You Pay Nothing AD	20% AD
21. Additional Professional Services – Billed by professional	20% AD	40% AD	You Pay Nothing AD	20% AD
22. Inpatient / Outpatient Physician, Surgeon, Assistant Surgeon	20% AD	40% AD	You Pay Nothing AD	20% AD
23. Organ Transplant Services – Lifetime maximum of $250,000 per member.	20% AD	Participating Providers Only	You Pay Nothing AD	Participating Providers Only
24. Inpatient Physiotherapy Services – Limited to 30 days per member/calendar year	20% AD	40% AD	You Pay Nothing AD	20% AD
Maternity Services	No Coverage	No Coverage	No Coverage	No Coverage

- This summary is for illustrative purposes only. For complete benefit disclosure, refer to the medical benefits brochure in the policy or call Customer Service 1-800-377-4161.
*Deductibles, Lifetime Maximums, and Out-of-Pocket Maximums are cumulative across all levels.
AD = After Deductible

Benefits Summary Comparison CONT'D

Benefits	QHDHP 80% Par	QHDHP 80% Non-Par	QHDHP 100% Par	QHDHP 100% Non-Par
Prescription Drugs**				
25. Prescription Drugs – 30 day supply (Preferred Generic / Preferred Brand / Non-Preferred)	$15 / $30 / $60 After Medical Deductible	Participating Providers Only	You Pay Nothing AD	Participating Providers Only
Injectable or implantable Medications				
26. Injectable or implantable Medications – Facility	20% AD	40% AD	You Pay Nothing AD	20% AD
27. Injectable or implantable Medications – Non-Facility (Preferred / Non-Preferred)	20% AD / 30% AD	40% AD/50% AD	You Pay Nothing AD	20% AD/30% AD
28. Injectable or implantable Medications – Pharmacy (Preferred / Non-Preferred)	20% AD / 30% AD	Participating Providers Only	You Pay Nothing AD	Participating Providers Only
Allergy Conditions				
29. Testing & Treatment	20% AD	40% AD	You Pay Nothing AD	20% AD
30. Serum	20% AD	40% AD	You Pay Nothing AD	20% AD
31. Injections	20% AD	40% AD	You Pay Nothing AD	20% AD
Other Benefits				
32. Accident Related Dental Services – $1,000 lifetime maximum	50% AD	Participating Benefit Applies	You Pay Nothing AD	Participating Benefit Applies
33. Durable Medical Equipment (DME) – $5,000 per member/calendar year	50% AD	50% AD	You Pay Nothing AD	50% AD
34. Home Health Care – 30 visits per member/calendar year	50% AD	50% AD	You Pay Nothing AD	50% AD
35. Hospice Care	20% AD	40% AD	You Pay Nothing AD	20% AD
36. Implantable Contraceptives and Intra-Uterine Devices (IUDs)	20% AD	40% AD	You Pay Nothing AD	20% AD
37. Infertility Services – Evaluation, testing, and diagnostic services; $750 per member/calendar year, up to a lifetime maximum of $5,000	50% AD	Participating Providers Only	You Pay Nothing AD	Participating Providers Only
38. Medical Supplies	50% AD	50% AD	You Pay Nothing AD	50% AD
39. Neuropsychological Testing	50% AD	50% AD	You Pay Nothing AD	50% AD
40. Skilled Nursing Facility – 30 days per member/calendar year	50% AD	50% AD	You Pay Nothing AD	50% AD
41. Sterilization Procedures – Physician's office	20% AD	40% AD	You Pay Nothing AD	20% AD
42. Sterilization Procedures – Outpatient facility	20% AD	40% AD	You Pay Nothing AD	20% AD
43. Temporomandibular Joint Dysfunction (TMJ) – Evaluation, testing and diagnostic services; lifetime maximum of $1,000	50% AD	50% AD	You Pay Nothing AD	50% AD
Mental Health and Substance Abuse	No Coverage	No Coverage	No Coverage	No Coverage

** If you receive a brand name drug when a preferred generic equivalent can be substituted, you will pay the difference in cost between the generic and the brand name drug, in addition to any applicable deductible and/or the generic copay. This difference does not apply to your deductible or out-of-pocket maximum. Regular benefits apply if a preferred generic cannot be substituted.