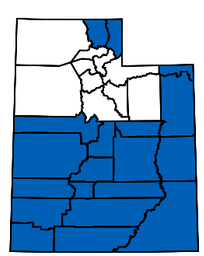
2014 Utah Individual Plans ON Exchange

POS

PLAN BENEFITS	Gold $5 Copay Plan		Silver $10 Copay Plan		Silver 1 $0 Copay Plan		Silver 2 $10 Copay Plan		Silver 3 $10 Copay Plan		Bronze $10 Copay Plan		Bronze Deductible Only HSA Eligible Plan		Catastrophic Deductible Only Plan	
	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Annual Deductible The amount you pay before your health insurance starts paying toward your costs	$1,750 Individual $3,500 Family	$6,400 Individual $12,800 Family	$3,750 Individual $7,500 Family	$6,400 Individual $12,800 Family	$0 Individual $0 Family	$6,400 Individual $12,800 Family	$1,750 Individual $3,500 Family	$6,400 Individual $12,800 Family	$3,750 Individual $7,500 Family	$6,400 Individual $12,800 Family	$5,600 Individual $11,200 Family	$6,400 Individual $12,800 Family	$6,300 Individual $12,600 Family	$6,400 Individual $12,800 Family	$6,350 Individual $12,700 Family	$6,400 Individual $12,800 Family
Annual Out-of-Pocket Maximum The costs you pay	$5,000 Individual $10,000 Family	Unlimited	$6,350 Individual $12,700 Family	Unlimited	$1,500 Individual $3,000 Family	Unlimited	$2,250 Individual $4,500 Family	Unlimited	$5,200 Individual $10,400 Family	Unlimited	$6,350 Individual $12,700 Family	Unlimited	$6,300 Individual $12,600 Family	Unlimited	$6,350 Individual $12,700 Family	Unlimited
Coinsurance Your responsibility after meeting your annual Deductible	20%	50%	30%	50%	10%	50%	0%	50%	30%	50%	30%	50%	0%	50%	0%	50%
Medical benefits shown with Copays are not subject to the Deductible unless specified	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In Network You Pay	Out-of-Network You Pay
Primary Physician Office Visit (PCP)	$5 Copay	50% Coinsurance AD	$10 Copay	50% Coinsurance AD	$0	50% Coinsurance AD	$10 Copay	50% Coinsurance AD	$10 Copay	50% Coinsurance AD	$10 Copay	50% Coinsurance AD	$0 AD	50% Coinsurance AD	First 3 visits - $20 Copay; 4+ visits - $0 AD	50% Coinsurance AD
Specialist Office Visit	First 5 visits - $50 Copay; 6+ visits - $50 Copay + Ded.	50% Coinsurance AD	First visit - $75 Copay; 2+ visits - $75 Copay + Ded.	50% Coinsurance AD	$25 Copay	50% Coinsurance AD	$50 Copay	50% Coinsurance AD	First visit - $75 Copay; 2+ visits - $75 Copay + Ded.	50% Coinsurance AD	$75 Copay + Ded.	50% Coinsurance AD	$0 AD	50% Coinsurance AD	$0 AD	50% Coinsurance AD
Preventive/Wellness Services (such as mammograms, well baby care, immunizations, etc.)	$0	50% Coinsurance AD	$0	50% Coinsurance AD	$0	50% Coinsurance AD	$0	50% Coinsurance AD	$0	50% Coinsurance AD	$0	50% Coinsurance AD	$0	50% Coinsurance AD	$0	50% Coinsurance AD
Routine lab (such as blood draw, urinalysis, PAP test, etc.) office visit or independent lab facility	Included in office visit	50% Coinsurance AD	Included in office visit	50% Coinsurance AD	Included in office visit	50% Coinsurance AD	Included in office visit	50% Coinsurance AD	Included in office visit	50% Coinsurance AD	Included in office visit	50% Coinsurance AD	$0 AD	50% Coinsurance AD	$0 AD	50% Coinsurance AD
Advanced imaging	Free standing facility - $250 Copay; Other - 20% Coinsurance AD	Outpatient - $250 Copay plus 50% Coinsurance AD; Other - 50% Coinsurance AD	Free standing facility - $250 Copay + Ded; Other - $250 Copay plus 30% Coinsurance AD	Free standing facility - 50% Coinsurance AD; Other - $250 Copay plus 50% Coinsurance AD	Free standing facility - $100 Copay; Other - 10% Coinsurance	Free standing facility - 50% Coinsurance AD; Other - $250 Copay plus 50% Coinsurance AD	Free standing facility - $0 Copay AD; Other - $100 Copay + Ded.	Free standing facility - 50% Coinsurance AD; Other - $250 Copay plus 50% Coinsurance AD	Free standing facility - $250 Copay + Ded; Other - $250 Copay plus 30% Coinsurance AD	Free standing facility - 50% Coinsurance AD; Other - $250 Copay plus 50% Coinsurance AD	Free standing facility - $250 Copay + Ded; Other - $250 Copay plus 30% Coinsurance AD	Free standing facility - 50% Coinsurance AD; Other - $250 Copay plus 50% Coinsurance AD	$0 AD	50% Coinsurance AD	$0 AD	50% Coinsurance AD
Urgent Care	$75 Copay	50% Coinsurance AD	$75 Copay	50% Coinsurance AD	$75 Copay	50% Coinsurance AD	$75 Copay	50% Coinsurance AD	$75 Copay	50% Coinsurance AD	$75 Copay + Ded.	50% Coinsurance AD	$0 AD	50% Coinsurance AD	$0 AD	50% Coinsurance AD
Emergency Care	First 3 visits - $250 Copay; 4+ visits - $250 Copay + Ded.	First 3 visits - $250 Copay; 4+ visits - $250 Copay + Ded.	First Visit - $500 Copay; 2+ visits - $500 Copay + Ded.	First Visit - $500 Copay; 2+ visits - $500 Copay + Ded.	$100 Copay	$100 Copay	First Visit - $100 Copay; 2+ visits - $100 Copay + Ded.	First Visit - $100 Copay; 2+ visits - $100 Copay AD	$500 Copay	$500 Copay	$500 Copay + Ded.	$500 Copay + Ded.	$0 AD	$0 AD	$0 AD	$0 AD
Maternity and Newborn Care	Prenatal office visits - $0; Physician services - $250 Copay; Facility - 20% Coinsurance AD	Physician services - 50% Coinsurance AD; Facility - $1,000 Copay plus 50% Coinsurance AD	Prenatal office visits - $0; Physician services -$250 Copay; Facility - $500 Copay plus 30% Coinsurance AD	Physician services - 50% Coinsurance AD; Facility - $1,000 Copay plus 50% Coinsurance AD	Prenatal office visits - $0; Physician services -$250 Copay; Facility - 10% Coinsurance	Physician services - 50% Coinsurance AD; Facility - $1,000 Copay plus 50% Coinsurance AD	Prenatal office visits - $0; Physician services -$250 Copay; Facility - $0 AD	Physician services - 50% Coinsurance AD; Facility - $1,000 Copay plus 50% Coinsurance AD	Prenatal office visits - $0; Physician services -$250 Copay; Facility - $500 Copay plus 30% Coinsurance AD	Physician services - 50% Coinsurance AD; Facility - $1,000 Copay plus 50% Coinsurance AD	Prenatal office visits - $0: Physician services: $500 Copay; Facility - $500 Copay plus 30% Coinsurance AD	Physician services - 50% Coinsurance AD; Facility - $1,000 Copay plus 50% Coinsurance AD	Prenatal office visits - $0; Other - $0 AD	50% Coinsurance AD	Prenatal office visits - $0; Other - $0 AD	50% Coinsurance AD
Inpatient Hospitalization	20% Coinsurance AD	Physician services - 50% Coinsurance AD; Facility - $1,000 Copay plus 50% Coinsurance AD	Physician services - 30% Coinsurance AD; Facility - $500 Copay plus 20% Coinsurance AD	Physician services - 50% Coinsurance AD; Facility - $1,000 Copay plus 50% Coinsurance AD	10% Coinsurance	Physician services - 50% Coinsurance AD; Facility - $1,000 Copay plus 50% Coinsurance AD	$0 AD	Physician services - 50% Coinsurance AD; Facility - $1,000 Copay plus 50% Coinsurance AD	Physician services - 30% Coinsurance AD; Facility - $500 Copay plus 30% Coinsurance AD	Physician services - 50% Coinsurance AD; Facility - $1,000 Copay plus 50% Coinsurance AD	Physician services - 30% Coinsurance AD; Facility - $500 Copay plus 30 % Coinsurance AD	Physician services - 50% Coinsurance AD; Facility - $1,000 Copay plus 50 % Coinsurance AD	$0 AD	50% Coinsurance AD	$0 AD	50% Coinsurance AD
Outpatient Surgery	Free standing facility - $250 Copay + Ded; Other - 20% Coinsurance AD	50% Coinsurance AD	Free standing facility - $250 Copay + Ded; Other - $250 Copay plus 30% Coinsurance AD	Free standing facility - 50% Coinsurance AD; Other - $250 Copay plus 50% Coinsurance AD	Free standing facility - $100 Copay; Other - 10% Coinsurance	Free standing facility - 50% Coinsurance AD; Other - $250 Copay plus 50% Coinsurance AD	Free standing facility - $0 AD; Other - $100 Copay + Ded.	Free standing facility - 50% Coinsurance AD; Other - $250 Copay plus 50% Coinsurance AD	Free standing facility - $250 Copay + Ded; Other - $250 Copay plus 30% Coinsurance AD	Free standing facility - 50% Coinsurance AD; Other - $250 Copay plus 50% Coinsurance AD	Free standing facility - $250 Copay + Ded; Other - $250 Copay plus 30% Coinsurance AD	Free standing facility - 50% Coinsurance AD; Other - $250 Copay plus 50% Coinsurance AD	$0 AD	50% Coinsurance AD	$0 AD	50% Coinsurance AD
Outpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) Limited to 20 visits per year for all therapies combined.	20% Coinsurance AD	50% Coinsurance AD	30% Coinsurance AD	50% Coinsurance AD	10% Coinsurance	50% Coinsurance AD	$0 AD	50% Coinsurance AD	30% Coinsurance AD	50% Coinsurance AD	30% Coinsurance AD	50% Coinsurance AD	$0 AD	50% Coinsurance AD	$0 AD	50% Coinsurance AD
Pediatric Vision* One pair of eyeglasses with frame or contact lenses per year; one routine eye exam	$0	40% Coinsurance AD	$0	40% Coinsurance AD	$0	40% Coinsurance AD	$0	40% Coinsurance AD	$0	40% Coinsurance AD	$0	40% Coinsurance AD	$0	40% Coinsurance AD	$0	40% Coinsurance AD
Mental Health	First 5 office visits - $50 Copay; 6+ visits - $50 Copay + Ded; Outpatient, partial hospitalization, and inpatient services – 20% Coinsurance AD	Office and Outpatient services - 50% Coinsurance AD; Inpatient services - $1,000 Copay plus 50% Coinsurance AD	First office visit - $75 Copay; 2+ visits - $75 Copay + Ded; Outpatient and partial hospitalization - 30% Coinsurance AD; Inpatient services - $500 Copay plus 30% Coinsurance AD	Office and Outpatient services - 50% Coinsurance AD; Inpatient Services - $1,000 Copay plus 50% Coinsurance AD	Office - $25 Copay; Outpatient, partial hospitalization, and inpatient services - 10% Coinsurance	Office and Outpatient services - 50% Coinsurance AD; Inpatient Services - $1,000 Copay plus 50% Coinsurance AD	Office - $50 Copay; Outpatient, partial hospitalization, and inpatient services - $0 AD	Office and Outpatient services - 50% Coinsurance AD; Inpatient Services - $1,000 Copay plus 50% Coinsurance AD	First office visit - $75 Copay; 2+ visits - $75 Copay + Ded; Outpatient and partial hospitalization - 30% Coinsurance AD; Inpatient services - $500 Copay plus 30% Coinsurance AD	Office and Outpatient services - 50% Coinsurance AD; Inpatient Services - $1,000 Copay plus 50% Coinsurance AD	Office visit - $75 Copay + Ded; Outpatient and partial hospitalization - 30% Coinsurance AD; Inpatient services - $500 Copay plus 30% Coinsurance AD	Office and Outpatient services - 50% Coinsurance AD; Inpatient services - $1,000 Copay plus 50% Coinsurance AD	$0 AD	50% Coinsurance AD	$0 AD	50% AD
Pharmacy	**Separate $250 Pharmacy Deductible per Individual on Tiers 2-5**		**Separate $1000 Pharmacy Deductible per Individual on Tiers 2-5**		**No Pharmacy Deductible**		**No Pharmacy Deductible**		**Separate $1000 Pharmacy Deductible per Individual on Tiers 2-5**		**Integrated Medical and Pharmacy Deductible**		**Integrated Medical and Pharmacy Deductible**		**Integrated Medical and Pharmacy Deductible**	
- **Tier 1A:** Lower Cost Preferred Generic Drugs	Preferred Pharmacy $3 Copay Non Preferred Pharmacy $10 Copay Mail Order $6 Copay		Preferred Pharmacy $5 Copay Non Preferred Pharmacy $20 Copay Mail Order $10 Copay		Preferred Pharmacy $3 Copay Non Preferred Pharmacy $10 Copay Mail Order $6 Copay		Preferred Pharmacy $5 Copay Non Preferred Pharmacy $15 Copay Mail Order $20 Copay		Preferred Pharmacy $5 Copay Non Preferred Pharmacy $20 Copay Mail Order $10 Copay		N/A		NA		NA	
- **Tier 1:** Preferred Generic Drugs	Preferred Pharmacy $5 Copay Non Preferred Pharmacy $10 Copay Mail Order $10 Copay		Preferred Pharmacy $15 Copay Non Preferred Pharmacy $20 Copay Mail Order $30 Copay		Preferred Pharmacy $5 Copay Non Preferred Pharmacy $10 Copay Mail Order $10 Copay		Preferred Pharmacy $10 Copay Non Preferred Pharmacy $15 Copay Mail Order $20 Copay		Preferred Pharmacy $15 Copay Non Preferred Pharmacy $20 Copay Mail Order $30 Copay		Preferred Pharmacy $15 Copay Non Preferred Pharmacy $20 Copay Mail Order $30 Copay		$0 AD		$0 AD	
- **Tier 2:** Preferred Brand Drugs	Preferred Pharmacy $30 Copay APD Non Preferred Pharmacy $40 Copay APD Mail Order $75 Copay APD		Preferred Pharmacy $45 APD Non-Preferred Pharmacy $55 APD Mail Order $112.50 APD		Preferred Pharmacy $30 Copay Non Preferred Pharmacy $40 Copay Mail Order $75 Copay		Preferred Pharmacy $35 Non Preferred Pharmacy $45 Mail Order $87.50		Preferred Pharmacy $45 Copay APD Non Preferred Pharmacy $55 Copay APD Mail Order $112.50 Copay APD		Preferred Pharmacy $45 Copay APD Non Preferred Pharmacy $55 Copay AD Mail Order $112.50 Copay AD		$0 AD		$0 AD	
- **Tier 3:** Non-Preferred Brand/Generic Drugs	Preferred Pharmacy $60 APD Non Preferred Pharmacy $75 APD Mail Order $180 APD		Preferred Pharmacy $75 Copay APD Non-Preferred Pharmacy $85 APD Mail Order $225 Copay APD		Preferred Pharmacy $55 Copay Non Preferred Pharmacy $65 Copay Mail Order $165 Copay		Preferred Pharmacy $75 Copay Non Preferred Pharmacy $85 Mail Order $225 Copay		Preferred Pharmacy $75 Copay APD Non Preferred Pharmacy $85 Copay APD Mail Order $225 Copay APD		Preferred Pharmacy $75 AD Non Preferred Pharmacy $85 AD Mail Order $225 AD		$0 AD		$0 AD	
- **Tier 4:** Preferred Specialty Drugs	Preferred Pharmacy 20% Coinsurance APD		Preferred Pharmacy 30% Coinsurance APD		Preferred Pharmacy 20% Coinsurance		Preferred Pharmacy 30% Coinsurance		Preferred Pharmacy 30% Coinsurance APD		Preferred Pharmacy 30% Coinsurance AD		$0 AD		$0 AD	
- **Tier 5:** Non-preferred Specialty Drugs	Preferred Pharmacy 30% Coinsurance APD		Preferred Pharmacy 40% Coinsurance APD		Preferred Pharmacy 30% Coinsurance		Preferred Pharmacy 40% Coinsurance		Preferred Pharmacy 40% Coinsurance APD		Preferred Pharmacy 40% Coinsurance AD		$0 AD		$0 AD	

Deductibles, Copays and Coinsurance apply to the Annual Out-of-Pocket Maximum
AD = After Deductible; APD = After Pharmacy Deductible
Benefit limitations are combined for In-Network and Out-of-Network services.
You pay all charges above Eligible Medical Expenses (EME) for Out-of-Network services.
*This benefit is only available for children who are under the age of 19.

This summary is provided for informational purposes only. Please refer to the Individual Contract and Schedule of Benefits to determine exact terms, conditions, and scope of coverage, including all exclusions and limitations and defined terms.



CHAL0510