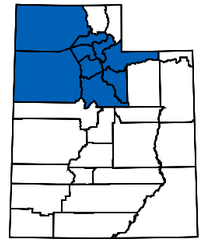
2014 Utah Individual Plans OFF Exchange

Peak Preference HMO

PLAN BENEFITS	Gold $0 Peak Preference		Silver $10 Copay Peak Preference		Bronze $15 Peak Preference		Bronze Peak Preference HSA Eligible		Catastrophic Deductible Only Peak Preference
	Tier 1 Limited Network You Pay	Tier 2 Altius Network You Pay	Tier 1 Limited Network You Pay	Tier 2 Altius Network You Pay	Tier 1 Limited Network You Pay	Tier 2 Altius Network You Pay	Tier 1 Limited Network You Pay	Tier 2 Altius Network You Pay	Tier 1 Limited Network You Pay
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited
Annual Deductible The amount you pay before your health insurance starts paying toward your costs	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family	$3,750 Individual $7,500 Family	$6,000 Individual $12,000 Family	$5,500 Individual 11,000 Family	$6,000 Individual $12,000 Family	$5,500 Individual $11,000 Family	$6,000 Individual $12,000 Family	$6,350 Individual $12,700 Family
Annual Out-of-Pocket Maximum The costs you pay	$5,000 Individual $10,000 Family	$6,000 Individual $12,000 Family	$6,350 Individual $12,700 Family	$6,350 Individual $12,700 Family	$6,350 Individual $12,700 Family	$6,350 Individual $12,700 Family	$6,350 Individual $12,700 Family	$6,350 Individual $12,700 Family	$6,350 Individual $12,700 Family
Coinsurance Your responsibility after meeting your annual Deductible	20%	40%	30%	45%	30%	45%	30%	45%	0%
Medical benefits shown with Copays are not subject to the Deductible unless specified	Tier 1 Limited Network You Pay	Tier 2 Altius Network You Pay	Tier 1 Limited Network You Pay	Tier 2 Altius Network You Pay	Tier 1 Limited Network You Pay	Tier 2 Altius Network You Pay	Tier 1 Limited Network You Pay	Tier 2 Altius Network You Pay	In Network You Pay
Primary Physician Office Visit (PCP)	$0	$25 Copay	$10 Copay	$50 Copay + Ded.	$15 Copay	$50 Copay + Ded.	30% Coinsurance AD	45% Coinsurance AD	First 3 visits - $20 Copay; 4+ visits - $0 AD
Specialist Office Visit	First 5 visits - $40 Copay; 6+ visits - $40 Copay + Ded.	$75 Copay + Ded.	First 2 visits - $75 Copay; 3+ visits - $75 Copay + Ded.	$75 Copay + Ded.	First visit - $75 Copay; 2+ visits - $75 Copay + Ded.	$100 Copay + Ded.	30% Coinsurance AD	45% Coinsurance AD	$0 AD
Preventive/Wellness Services (such as mammograms, well baby care, immunizations, etc.)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Routine lab (such as blood draw, urinalysis, PAP test, etc.) office visit or independent lab facility	Included in office visit	40% Coinsurance AD	Included in office	45% Coinsurance AD	Included in office visit	45% Coinsurance AD	Included in office visit	45% Coinsurance AD	$0 AD
Advanced imaging	Free standing facility - $250 Copay; Other - 20% Coinsurance AD	Free standing facility - 40% Coinsurance AD; Outpatient - $100 Copay plus 40% Coinsurance AD; Other - 40% Coinsurance AD	Free standing facility - $100 Copay + Ded; Other - $100 Copay plus 30% Coinsurance AD	Free standing facility - 45% Coinsurance AD; Other - $250 Copay plus 45% Coinsurance AD	Free standing facility - $250 Copay AD; Other -$250 Copay plus 30% Coinsurance AD	Free standing facility - 45% Coinsurance AD; Other - $500 Copay plus 45% Coinsurance AD	30% Coinsurance AD	45% Coinsurance AD	$0 AD
Urgent Care	$75 Copay	$150 Copay	$75 Copay	45% Coinsurance AD	$150 Copay	$150 Copay AD	30% Coinsurance AD	45% Coinsurance AD	$0 AD
Emergency Care	First 3 visits - $250 Copay; 4+ visits - $250 Copay + Ded.	$250 Copay + Ded.	First 2 visits - $500 Copay; 3+ visits - $500 Copay + Ded.	$750 Copay + Ded.	First visit - $500 Copay; 2+ visits - $500 Copay AD	$750 Copay AD	30% Coinsurance AD	45% Coinsurance AD	$0 AD
Maternity and Newborn Care	Prenatal office visits - $0; Physician services - $250 Copay; Facility - 20% Coinsurance AD	Prenatal office visits - $500 Copay; Physician services - $0; Facility - $250 Copay plus 40% Coinsurance AD	Prenatal office visits - $0; Physician services - $250 Copay; Facility - $250 Copay plus 30% Coinsurance AD	Prenatal office visits - $0 AD; Physician services - $0 AD Coinsurance AD; Facility - $500 Copay plus 45% Coinsurance AD	Prenatal office visits - $0; Physician services - $500 Copay; Facility - $500 Copay plus 30% Coinsurance AD	Prenatal office visits - $0 AD; Physician services - $0 AD; Facility - $1,000 Copay 45% Coinsurance AD	Prenatal office visits - $0; Physician and facility services -30% Coinsurance AD	Prenatal office visits - $0; Physician and facility services -45% Coinsurance AD	$0 AD
Inpatient Hospitalization	20% Coinsurance AD	Physician services - 40% Coinsurance AD; Facility - $250 Copay plus 40% Coinsurance AD	Physician services - 30% Coinsurance AD; Facility - $250 Copay plus 30% Coinsurance AD	Physician services - 45% Coinsurance AD; Facility - $500 Copay plus 45% Coinsurance AD	Physician services - 30% Coinsurance AD; Facility - $500 Copay plus 30% Coinsurance AD	Physician services - 45% Coinsurance AD; Facility - $1,000 Copay plus 45% Coinsurance AD	30% Coinsurance AD	45% Coinsurance AD	$0 AD
Outpatient Surgery	Free standing facility - $250 Copay + Ded; Other - 20% Coinsurance AD	Free standing facility - 40% Coinsurance AD; Outpatient - $100 Copay plus 40% Coinsurance AD; Other - 40% Coinsurance AD	Free standing facility - $100 Copay + Ded; Other - $100 Copay plus 30% Coinsurance AD	Free standing facility - 45% Coinsurance AD; Outpatient - $250 Copay plus 45% Coinsurance AD; Other - 45% Coinsurance AD	Free standing facility - $250 Copay + Ded; Other -$250 Copay plus 30% Coinsurance AD	Free standing facility - 45% Coinsurance AD; Other - $500 Copay plus 45% Coinsurance AD	30% Coinsurance AD	45% Coinsurance AD	$0 AD
Outpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) Limited to 25 visits per year for all therapies combined.	20% Coinsurance AD	40% Coinsurance AD	30% Coinsurance AD	45% Coinsurance AD	30% Coinsurance AD	45% Coinsurance AD	30% Coinsurance AD	45% Coinsurance AD	$0 AD
Pediatric Dental*	Preventive and Diagnostic - $0		Preventive and Diagnostic - $0		Preventive and Diagnostic - $0		Preventive and Diagnostic - $0		Preventive and Diagnostic - $0
Pediatric Vision* One pair of eyeglasses with frame or contact lenses per year; one routine eye exam	$0		$0		$0		$0		$0
Mental Health	First 5 office visits - $40 Copay; 6+ visits - $40 Copay + Ded; Outpatient, partial hospitalization, and inpatient services - 20% Coinsurance AD	Office visits - $75 Copay + Ded; Outpatient and partial hospitalization - 40% Coinsurance AD; Inpatient services - $250 Copay plus 40% Coinsurance AD	Office visits - First 2 visits: $75 Copay; 3+ visits: $75 Copay + Ded; Outpatient, partial hospitalization - 30% Coinsurance AD; Inpatient services - $250 Copay plus 30% Coinsurance AD	Office visits - 45% Coinsurance AD; Outpatient and partial hospitalization - 45% Coinsurance AD; Inpatient services - $500 Copay plus 45% Coinsurance AD	First visit - $75 Copay; 2+ visits - $75 Copay + Ded; Outpatient and partial hospitalization - 30% Coinsurance AD; Inpatient services - $500 Copay plus 30% Coinsurance AD	Physician services and outpatient and partial hospitalization- 45% Coinsurance AD; Facility - $1,000 Copay plus 45% Coinsurance AD	30% Coinsurance AD	45% Coinsurance AD	$0 AD
Pharmacy	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 $15 Copay Mail Order $10 Copay		N/A		NA		N/A
- **Tier 1:** Preferred Generic Drugs	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 Pharmacy30% Coinsurance AD Non Preferred Pharmacy 40% Coinsurance AD Mail Order 30% Coinsurance AD		$0 AD
- **Tier 2:** Preferred Brand Drugs	Preferred Pharmacy $30 Copay Non Preferred Pharmacy $40 Copay Mail Order $75 Copay		Preferred Pharmacy $45 Copay APD Non Preferred Pharmacy $55 Copay APD Mail Order $112.50 Copay APD		Preferred Pharmacy $45 Copay AD Non Preferred Pharmacy $55 Copay AD Mail Order $112.50 Copay AD		Preferred Pharmacy30% Coinsurance AD Non Preferred Pharmacy 40% Coinsurance AD Mail Order 30% Coinsurance AD		$0 AD
- **Tier 3:** Non-Preferred Brand/Generic Drugs	Preferred Pharmacy $55 Copay Non Preferred Pharmacy $65 Copay Mail Order $165 Copay		Preferred Pharmacy $75 Copay APD Non Preferred Pharmacy $85 Copay APD Mail Order $225 Copay APD		Preferred Pharmacy $75 Copay AD Non Preferred Pharmacy $85 Copay AD Mail Order $225 Copay AD		Preferred Pharmacy40% Coinsurance AD Non Preferred Pharmacy 50% Coinsurance AD Mail Order 40% Coinsurance AD		$0 AD
- **Tier 4:** Preferred Specialty Drugs	Preferred Pharmacy 20% Coinsurance		Preferred Pharmacy 30% Coinsurance APD		Preferred Pharmacy 30% Coinsurance AD		Preferred Pharmacy 40% Coinsurance AD		$0 AD
- **Tier 5:** Non-preferred Specialty Drugs	Preferred Pharmacy 30% Coinsurance		Preferred Pharmacy 40% Coinsurance APD		Preferred Pharmacy 40% Coinsurance AD		Preferred Pharmacy 50% Coinsurance 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 for Tier 1 and Tier 2 services.
There is no coverage for Out-of-Network services other than emergency care or out-of-area urgent care.
*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.



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