Bronze Aetna Health of Utah Inc. dba Altius Health Plans Inc.

Plan	UT Altius Bronze HSA Eligible Peak Preference PD	
Member Benefits	**Designated**	**Non-designated**
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$5,500/$11,000	$6,000/$12,000
Member coinsurance	30% coinsurance	45% coinsurance
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$6,400/$12,800	$6,400/$12,800
Primary care visit	30% coinsurance after ded	45% coinsurance after ded
Specialist visit	30% coinsurance after ded	45% coinsurance after ded
Hospital stay	30% coinsurance after ded	45% coinsurance after ded
Outpatient surgery (ambulatory surgical center/hospital)	30% coinsurance after ded	45% coinsurance after ded
Emergency room (copay waived if admitted and hospital stay benefit applies; non-designated benefit applies to emergency room care received from non-participating providers)	30% coinsurance after ded	45% coinsurance after ded
Urgent care	30% coinsurance after ded	45% coinsurance after ded
Preventive care[2] (age and frequency visit limits apply)	Covered in full, ded waived	Covered in full, ded waived
Diagnostic lab	30% coinsurance after ded	45% coinsurance after ded
Diagnostic X-ray	30% coinsurance after ded	45% coinsurance after ded
Imaging (CT/PET scans, MRIs)	30% coinsurance after ded	45% coinsurance after ded
Vision		
Pediatric eye exam[2] (1 visit per year)	Covered in full after ded	Paid at the designated level
Pediatric dental		
Dental checkup/preventive dental care[2] (2 visits per year)	Covered in full after ded	Paid at the designated level
Basic dental care	Not covered	Not covered
Pharmacy*,**	**In-Network**	**Out-of-Network*****
Pharmacy deductible	Integrated with medical ded	Integrated with medical ded
Preferred generic drugs	30% coinsurance after ded	Not covered
Preferred brand drugs	30% coinsurance after ded	Not covered
Non-Preferred drugs†	40% coinsurance after ded	Not covered
Specialty drugs††	P: 40% coinsurance after ded NP: 50% coinsurance after ded	Not covered

*If the physician prescribes or the member requests a covered brand name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent plus the applicable cost-sharing. The cost difference between the generic and brand does not count toward the out-of-pocket limit.

**Not all drugs are covered. It is important to look at the Drug List to understand which drugs are covered.

***For important information on your costs and how out-of-network care is paid, read "Section 1 Using Your Benefits" in your Certificate of Coverage.

Health benefits and health insurance plans are underwritten by Aetna Health of Utah, Inc. dba Altius Health Plans, Inc.

Bronze Aetna Health of Utah Inc. dba Altius Health Plans Inc.
(Continued)

UT Altius Bronze $15 Copay Peak Preference PD

Designated	Non-designated
$6,000/$12,000	$6,500/$13,000
30% coinsurance	45% coinsurance
$6,600/$13,200	$6,600/$13,200
$15 copay, ded waived	$50 copay after ded
Visit 1: $75 copay, ded waived Visits 2+: $75 copay after ded	$100 copay after ded
$500 copay per admission after ded, then 30% coinsurance	$1,000 copay per admission after ded, then 45% coinsurance
Hospital outpatient: $250 copay after ded, then 30% coinsurance, Free-Standing Outpatient Facility: $250 copay after ded	Hospital outpatient: $500 copay after ded, then 45% coinsurance, Free-Standing Outpatient Facility: 45% coinsurance after ded
Visit 1: $500 copay, ded waived Visits 2+: $500 copay after ded	$750 copay after ded, then 45% coinsurance
$150 copay, ded waived	$150 copay after ded
Covered in full, ded waived	Covered in full, ded waived
Covered in full after ded	Covered in full after ded
30% coinsurance after ded	45% coinsurance after ded
$250 copay after ded, then 30% coinsurance	$500 copay after ded, then 45% coinsurance
Covered in full, ded waived	Paid at the designated level
Covered in full, ded waived	Paid at the designated level
Not covered	Not covered
In-Network	**Out-of-Network*** **
Integrated with medical ded; waived for preferred generic drugs	Integrated with medical ded; waived for preferred generic drugs
P: $15 copay, NP: $20 copay†††	Not covered†††
P: $45, after ded, NP: $55 after ded	Not covered
P: $75 after ded, NP: $85 after ded	Not covered
P: 30% coinsurance after ded NP: 40% after ded	Not covered

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†Includes Non-preferred generic and brand drugs.

††P = Preferred specialty drugs; NP = Non-Preferred specialty drugs.

†††P = Preferred in-network pharmacy; NP = Non-Preferred in-network pharmacy.

[1]The family deductible and/or out-of-pocket limit can be met by a combination of family members. Each covered family member only needs to satisfy his or her individual deductible and/or out-of-pocket limit. Deductible and/or out-of-pocket limits are cummulative for designated and non-designated.

[2]Any applicable benefit maximums are combined designated and non-designated.

80.06.301.1-UT (1/15)

Silver Aetna Health of Utah Inc. dba Altius Health Plans Inc.

Plan	UT Altius Silver $5 Copay 2750 Peak Preference PD	
Member Benefits	**Designated**	**Non-designated**
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$2,500/$5,000	$5,250/$10,500
Member coinsurance	30% coinsurance	45% coinsurance
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$5,750/$11,500	$6,250/$12,500
Primary care visit	$5 copay, ded waived	$40 copay after ded
Specialist visit	Visits 1–2: $45 copay, ded waived Visits 3+: $45 copay after ded	$60 copay after ded
Hospital stay	30% coinsurance after ded	$500 copay per admission after ded, then 45% coinsurance
Outpatient surgery (ambulatory surgical center/hospital)	30% coinsurance after ded	$250 copay after ded, then 45% coinsurance
Emergency room (copay waived if admitted and hospital stay benefit applies; non-designated benefit applies to emergency room care received from non-participating providers)	Visits 1–2: $250 copay, ded waived Visits 3+: $250 copay after ded	$500 copay after ded
Urgent care	$75 copay, ded waived	45% coinsurance after ded
Preventive care[2] (age and frequency visit limits apply)	Covered in full, ded waived	Covered in full, ded waived
Diagnostic lab	30% coinsurance after ded	45% coinsurance after ded
Diagnostic X-ray	30% coinsurance after ded	45% coinsurance after ded
Imaging (CT/PET scans, MRIs)	30% coinsurance after ded	$250 copay after ded, then 45% coinsurance
Vision		
Pediatric eye exam[2] (1 visit per year)	Covered in full, ded waived	Paid at the designated level
Pediatric dental		
Dental checkup/preventive dental care[2] (2 visits per year)	Covered in full, ded waived	Paid at the designated level
Basic dental care	Not covered	Not covered
Pharmacy*,**	**In-Network**	**Out-of-Network*****
Pharmacy deductible†	Integrated with medical ded; waived for Tiers T1A & T1†	Integrated with medical ded; waived for Tiers T1A & T1†
Preferred generic drugs††	P: T1A - $3 copay/T1 - $5 copay NP: T1A - $10 copay/T1 - $10 copay	Not covered
Preferred brand drugs	P: $35 copay after ded NP: $45 copay after ded	Not covered
Non-Preferred drugs†††	P: $75copay after ded NP: $85 copay after ded	Not covered
Specialty drugs‡	P: 30% coinsurance after ded NP : 40% coinsurance after ded	Not covered

*If the physician prescribes or the member requests a covered brand name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent plus the applicable cost-sharing. The cost difference between the generic and brand does not count toward the out-of-pocket limit.

**Not all drugs are covered. It is important to look at the Drug List to understand which drugs are covered.

***For important information on your costs and how out-of-network care is paid, read "Section 1 Using Your Benefits" in your Certificate of Coverage.

†T1A = Lower cost preferred generic drugs; T1 = Preferred generic drugs.

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80.06.301.1-UT (1/15)

††P = Preferred in-network pharmacy; NP = Non-preferred in-network pharmacy.

†††Includes Non-preferred generic and brand drugs.

‡P = Preferred specialty drugs; NP = Non-Preferred specialty drugs.

[1]The family deductible and/or out-of-pocket limit can be met by a combination of family members. Each covered family member only needs to satisfy his or her individual deductible and/or out-of-pocket limit. Deductible and/or out-of-pocket limits are cummulative for designated and non-designated.

[2]Any applicable benefit maximums are combined designated and non-designated.

Silver Aetna Health of Utah Inc. dba Altius Health Plans Inc.

Plan	UT Altius Silver $10 Copay Peak Preference PD
Member Benefits	**Designated**
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$3,750/$7,500
Member coinsurance	30% coinsurance
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$6,400/$12,800
Primary care visit	$10 copay, ded waived
Specialist visit	Visits 1–2: $75 copay, ded waived Visits 3+: $75 copay after ded
Hospital stay	$250 copay per admission after ded, then 30% coinsurance
Outpatient surgery (ambulatory surgical center/hospital)	Hospital outpatient: $100 copay after ded, then 30% coinsurance, Free-Standing Outpatient Facility: $100 copay after ded
Emergency room (copay waived if admitted and hospital stay benefit applies; non-designated benefit applies to emergency room care received from non-participating providers)	Visit 1: $500 copay, ded waived Visits 2+: $500 copay after ded
Urgent care	$75 copay, ded waived
Preventive care[2] (age and frequency visit limits apply)	Covered in full, ded waived
Diagnostic lab	30% coinsurance after ded
Diagnostic X-ray	30% coinsurance after ded
Imaging (CT/PET scans, MRIs)	$100 copay after ded, then 30% coinsurance
Vision	
Pediatric eye exam[2] (1 visit per year)	Covered in full, ded waived
Pediatric dental	
Dental checkup/preventive dental care[2] (2 visits per year)	Covered in full, ded waived
Basic dental care	Not covered
Pharmacy*,**	**In-Network**
Pharmacy deductible†	$1,000 ded per member; waived for Tiers T1A & T1
Preferred generic drugs††	P: T1A - $3 copay /T1 - $5 copay NP: T1A - $10 copay /T1 - $10 copay
Preferred brand drugs	P: $45 copay, after ded NP: $55 copay after ded
Non-Preferred drugs†††	P: $75 copay after ded NP: $85 copay after ded
Specialty drugs‡	P: 30% coinsurance after ded NP: 40% coinsurance after ded

*If the physician prescribes or the member requests a covered brand name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent plus the applicable cost-sharing. The cost difference between the generic and brand does not count toward the out-of-pocket limit.

**Not all drugs are covered. It is important to look at the Drug List to understand which drugs are covered.

***For important information on your costs and how out-of-network care is paid, read "Section 1 Using Your Benefits" in your Certificate of Coverage.

†T1A = Lower cost preferred generic drugs; T1 = Preferred generic drugs.

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Silver Aetna Health of Utah Inc. dba Altius Health Plans Inc.
(Continued)

UT Altius Silver $10 Copay Peak Preference PD (continued)

Non-designated
$5,500/$11,000
45% coinsurance
$6,600/$13,200
$50 copay after ded
$75 copay after ded
$500 copay per admission after ded then, 45% coinsurance
Hospital outpatient: $250 copay after ded, then 45% coinsurance, Free-Standing Outpatient Facility: 45% coinsurance after ded
$750 copay after ded
45% coinsurance after ded
Covered in full, ded waived
45% coinsurance after ded
45% coinsurance after ded
$250 copay after ded, then 45% coinsurance
Paid at the designated level
Paid at the designated level
Not covered
Out-of-Network* **
$1,000 ded per member; waived for Tiers T1A & T1
Not covered
Not covered
Not covered
Not covered

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††P = Preferred in-network pharmacy; NP = Non-preferred in-network pharmacy.

†††Includes Non-preferred generic and brand drugs.

‡P = Preferred specialty drugs; NP = Non-Preferred specialty drugs.

[1]The family deductible and/or out-of-pocket limit can be met by a combination of family members. Each covered family member only needs to satisfy his or her individual deductible and/or out-of-pocket limit. Deductible and/or out-of-pocket limits are cummulative for designated and non-designated.

[2]Any applicable benefit maximums are combined designated and non-designated.

Gold Aetna Health of Utah Inc. dba Altius Health Plans Inc.

Plan	**UT Altius Gold $0 Copay Peak Preference PD**	
Member Benefits	**Designated**	**Non-designated**
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$1,000/$2,000	$2,000/$4,000
Member coinsurance	20% coinsurance	40% coinsurance
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$4,000/$8,000	$6,000/$12,000
Primary care visit	Covered in full, ded waived	$25 copay, ded waived
Specialist visit	Visits 1–6: $40 copay, ded waived Visits 7+: $40 copay after ded	$75 copay after ded
Hospital stay	20% coinsurance after ded	$250 copay per admission after ded, then 40% coinsurance
Outpatient surgery (ambulatory surgical center/hospital)	20% coinsurance after ded	40% coinsurance after ded
Emergency room (copay waived if admitted and hospital stay benefit applies; non-designated benefit applies to emergency room care received from non-participating providers)	Visits 1–3: $250 copay, ded waived Visits 4+: $250 copay after ded	$250 copay after ded
Urgent care	$75 copay, ded waived	$150 copay, ded waived
Preventive care[2] (age and frequency visit limits apply)	Covered in full, ded waived	Covered in full, ded waived
Diagnostic lab	20% coinsurance after ded	40% coinsurance after ded
Diagnostic X-ray	20% coinsurance after ded	40% coisnurance after ded
Imaging (CT/PET scans, MRIs)	20% coinsurance after ded	$100 copay after ded, then 40% coinsurance
Vision		
Pediatric eye exam[2] (1 visit per year)	Covered in full, ded waived	Paid at the designated level
Pediatric dental		
Dental checkup/preventive dental care[2] (2 visits per year)	Covered in full, ded waived	Paid at the designated level
Basic dental care	Not covered	Not covered
Pharmacy*,**	**In-Network**	**Out-of-Network*****
Pharmacy deductible	None	None
Preferred generic drugs†,††	P: T1A - $3 copay/T1 - $5 copay NP: T1A - $10 copay/T1 - $10 copay	Not covered
Preferred brand drugs	P: $25 copay, NP: $35 copay	Not covered
Non-Preferred drugs†††	P: $55 copay, NP: $65 copay	Not covered
Specialty drugs‡	P: 20% coinsurance NP: 30% coinsurance	Not covered

*If the physician prescribes or the member requests a covered brand name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent plus the applicable cost-sharing. The cost difference between the generic and brand does not count toward the out-of-pocket limit.

**Not all drugs are covered. It is important to look at the Drug List to understand which drugs are covered.

***For important information on your costs and how out-of-network care is paid, read "Section 1 Using Your Benefits" in your Certificate of Coverage.

†T1A = Lower cost preferred generic drugs; T1 = Preferred generic drugs.

††P = Preferred in-network pharmacy; NP = Non-preferred in-network pharmacy.

†††Includes Non-preferred generic and brand drugs.

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80.06.301.1-UT (1/15)

‡P = Preferred specialty drugs; NP = Non-Preferred specialty drugs.

[1]The family deductible and/or out-of-pocket limit can be met by a combination of family members. Each covered family member only needs to satisfy his or her individual deductible and/or out-of-pocket limit. Deductible and/or out-of-pocket limits are cummulative for designated and non-designated.

[2]Any applicable benefit maximums are combined designated and non-designated.

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Bronze Aetna Health of Utah Inc. dba Altius Health Plans Inc.

Plan	UT Altius Bronze HSA Eligible PD	
Member Benefits	**In-Network**	**Out-of-Network***
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$6,300/$12,600	$12,600/$25,200
Member coinsurance	0% coinsurance	50% coinsurance
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$6,300/$12,600	Unlimited
Primary care visit	Covered in full after ded	50% coinsurance after ded
Specialist visit	Covered in full after ded	50% coinsurance after ded
Hospital stay	Covered in full after ded	50% coinsurance after ded
Outpatient surgery (ambulatory surgical center/hospital)	Covered in full after ded	50% coinsurance after ded
Emergency room (copay waived if admitted and hospital stay benefit applies; non-designated benefit applies to emergency room care received from non-participating providers)	Covered in full after ded	Covered in full after ded
Urgent care	Covered in full after ded	50% coinsurance after ded
Preventive care[2] (age and frequency visit limits apply)	Covered in full, ded waived	50% coinsurance after ded
Diagnostic lab	Covered in full after ded	50% coinsurance after ded
Diagnostic X-ray	Covered in full after ded	50% coinsurance after ded
Imaging (CT/PET scans, MRIs)	Covered in full after ded	50% coinsurance after ded
Vision		
Pediatric eye exam[2] (1 visit per year)	Covered in full, ded waived	50% coinsurance after ded
Pediatric dental		
Dental checkup/preventive dental care[2] (2 visits per year)	Covered in full after ded	Paid at the designated level
Basic dental care	Not covered	Not covered
Pharmacy,***		
Pharmacy deductible	Integrated with medical ded	Integrated with medical ded
Preferred generic drugs	Covered in full after ded	50% coinsurance after ded
Preferred brand drugs	Covered in full after ded	50% coinsurance after ded
Non-Preferred drugs†	Covered in full after ded	50% coinsurance after ded
Specialty drugs††	Covered in full after ded	Not covered

*For important information on your costs and how out-of-network care is paid, read "Section 1 Using Your Benefits" in your Certificate of Coverage.

**Not all drugs are covered. It is important to look at the Drug List to understand which drugs are covered.

***If the physician prescribes or the member requests a covered brand name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent plus the applicable cost-sharing. The cost difference between the generic and brand does not count toward the out-of-pocket limit.

†Includes non-preferred generic and brand drugs.

††P = Preferred specialty drugs; NP = Non-preferred specialty drugs.

†††P = Preferred in-network pharmacy; NP = Non-preferred in-network pharmacy.

Health benefits and health insurance plans are underwritten by Aetna Health of Utah, Inc. dba Altius Health Plans, Inc.

Bronze Aetna Health of Utah Inc. dba Altius Health Plans Inc.
(Continued)

UT Altius Bronze $20 Copay PD

In-Network	Out-of-Network*
$5,750/$11,500	$11,500/$23,000
0% coinsurance	50% coinsurance
$6,600/$13,200	Unlimited
$20 copay, ded waived	50% coinsurance after ded
$50 copay after ded	50% coinsurance after ded
$250 copay per admission after ded	50% coinsurance after ded
$250 copay after ded	50% coinsurance after ded
$250 copay after ded	$250 copay after ded
$60 copay after ded	50% coinsurance after ded
Covered in full, ded waived	50% coinsurance after ded
Covered in full after ded	50% coinsurance after ded
$100 copay after ded	50% coinsurance after ded
$250 copay after ded	50% coinsurance after ded
Covered in full, ded waived	50% coinsurance after ded
Covered in full, ded waived	Paid at the designated level
Not covered	Not covered
Integrated with medical ded; waived for preferred generic drugs†††	Integrated with medical ded; waived for preferred generic drugs†††
P: $15 copay NP: $20 copay	50% coinsurance after ded
P: $45 copay after ded NP: $55 copay after ded	50% coinsurance after ded
P: $75 copay after ded NP: $85 copay after ded	50% coinsurance after ded
P: 40% coinsurance after ded NP: 50% coinsurance after ded	Not covered

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[1]The family deductible and/or out-of-pocket limit can be met by a combination of family members. Each covered family member only needs to satisfy his or her individual deductible and/or out-of-pocket limit. Deductible and/or out-of-pocket limits are cummulative for in and out-of-network.

[2]Any applicable benefit maximums are combined in and out-of-network.

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Silver Aetna Health of Utah Inc. dba Altius Health Plans Inc.

Plan	UT Altius Silver $10 Copay PD	
Member Benefits	**In-Network**	**Out-of-Network***
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$3,750/$7,500	$7,500/$15,000
Member coinsurance	30% coinsurance	50% coinsurance
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$6,600/$13,200	Unlimited
Primary care visit	$10 copay, ded waived	50% coinsurance after ded
Specialist visit	Visits 1–2: $75 copay, ded waived Visits 3+: $75 copay after ded	50% coinsurance after ded
Hospital stay	$500 copay per admission after ded, then 30% coinsurance	$1,000 copay per admission after ded, then 50% coinsurance
Outpatient surgery (ambulatory surgical center/hospital)	$250 copay after ded, then 30% coinsurance	$250 copay after ded, then 50% coinsurance
Emergency room (copay waived if admitted and hospital stay benefit applies; non-designated benefit applies to emergency room care received from non-participating providers)	$500 copay, ded waived for first visit	$500 copay, ded waived for first visit
Urgent care	$75 copay, ded waived	50% coinsurance after ded
Preventive care[2] (age and frequency visit limits apply)	Covered in full, ded waived	50% coinsurance after ded
Diagnostic lab	30% coinsurance after ded	50% coinsurance after ded
Diagnostic X-ray	30% coinsurance after ded	50% coinsurance after ded
Imaging (CT/PET scans, MRIs)	$250 copay after ded,then 30% coinsurance	$250 copay after ded, then 50% coinsurance
Vision		
Pediatric eye exam[2] (1 visit per year)	Covered in full, ded waived	50% coinsurance after ded
Pediatric dental		
Dental checkup/preventive dental care[2] (2 visits per year)	Covered in full, ded waived	Paid at the designated level
Basic dental care	Not covered	Not covered
Pharmacy,***		
Pharmacy deductible	$500 ded per member; waived for Tiers T1A & T1†	$1,000 ded per member
Preferred generic drugs††	P: T1A - $5 copay/T1 - $15 copay NP: T1A - $20 copay/T1 - $20 copay	50% coinsurance after ded
Preferred brand drugs	P: $45 copay after ded NP: $55 copay after ded	50% coinsurance after ded
Non-Preferred drugs†††	P: $75 copay after ded NP: $85 copay after ded	50% coinsurance after ded
Specialty drugs‡	P: 40% coinsurance after ded NP: 50% coinsurance after ded	Not covered

*For important information on your costs and how out-of-network care is paid, read "Section 1 Using Your Benefits" in your Certificate of Coverage.

**If the physician prescribes or the member requests a covered brand name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent plus the applicable cost-sharing. The cost difference between the generic and brand does not count toward the out-of-pocket limit.

***Not all drugs are covered. It is important to look at the Drug List to understand which drugs are covered.

†T1A = Lower cost preferred generic drugs; T1 = Preferred generic drugs.

Health benefits and health insurance plans are underwritten by Aetna Health of Utah, Inc. dba Altius Health Plans, Inc.

Silver Aetna Health of Utah Inc. dba Altius Health Plans Inc.
(Continued)

UT Altius Silver $5 Copay 2750 PD

In-Network	Out-of-Network*
$2,750/$5,500	$7,500/$15,000
40% coinsurance	50% coinsurance
$6,600/$13,200	Unlimited
$5 copay, ded waived	50% coinsurance after ded
Visits 1–2: $75 copay, ded waived Visits 3+: $75 copay after ded	50% coinsurance after ded
40% coinsurance after ded	$1,000 copay per admission after ded, then 50% coinsurance
40% coinsurance after ded	$250 copay after ded, then 50% coinsurance
$500 copay, ded waived for first visit	$500 copay, ded waived for first visit
$75 copay, ded waived	50% coinsurance after ded
Covered in full, ded waived	50% coinsurance after ded
40% coinsurance after ded	50% coinsurance after ded
40% coinsurance after ded	50% coinsurance after ded
40% coinsurance after ded	$250 copay after ded; then 50% coinsurance
Covered in full, ded waived	50% coinsurance after ded
Covered in full, ded waived	Paid at the designated level
Not covered	Not covered
Integrated with medical ded; waived for Tiers T1A & T1†	Integrated with medical ded; waived for Tiers T1A & T1†
P: T1A - $5 copay/T1 - $10 copay NP: T1A - $20 copay/T1 - $20 copay	50% coinsurance after ded
P: $45 copay after ded NP: $55 copay after ded	50% coinsurance after ded
P: $75 copay after ded NP: $85 copay after ded	50% coinsurance after ded
P: 40% coinsurance after ded NP: 50% coinsurance after ded	Not covered

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80.06.301.1-UT (1/15)

††P = Preferred in-network pharmacy; NP = Non-preferred in-network pharmacy.

†††Includes non-preferred generic and brand drugs.

‡P = Preferred specialty drugs; NP = Non-preferred specialty drugs.

[1]The family deductible and/or out-of-pocket limit can be met by a combination of family members. Each covered family member only needs to satisfy his or her individual deductible and/or out-of-pocket limit. Deductible and/or out-of-pocket limits are cummulative for in and out-of-network.

[2]Any applicable benefit maximums are combined in and out-of-network.

Gold Aetna Health of Utah Inc. dba Altius Health Plans Inc.

Plan	UT Altius Gold $5 Copay PD	
Member Benefits	**In-Network**	**Out-of-Network***
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$1,400/$2,800	$6,750/$13,500
Member coinsurance	20% coinsurance	50% coinsurance
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$5,650/$11,300	Unlimited
Primary care visit	$5 copay, ded waived	50% coinsurance after ded
Specialist visit	Visits 1–5: $50 copay, ded waived Visits 6+: $50 copay after ded	50% coinsurance after ded
Hospital stay	20% coinsurance after ded	$1,000 copay per admission after ded, then 50% coinsurance
Outpatient surgery (ambulatory surgical center/hospital)	20% coinsurance after ded	50% coinsurance after ded
Emergency room (copay waived if admitted and hospital stay benefit applies; non-designated benefit applies to emergency room care received from non-participating providers)	Visits 1–3: $250 copay, ded waived Visits 4+: $250 copay after ded	Visits 1–3: $250 copay, ded waived Visits 4+: $250 copay after ded
Urgent care	$75 copay, ded waived	50% coinsurance after ded
Preventive care[2] (age and frequency visit limits apply)	Covered in full, ded waived	50% coinsurance after ded
Diagnostic lab	20% coinsurance after ded	50% coinsurance after ded
Diagnostic X-ray	20% coinsurance after ded	50% coinsurance after ded
Imaging (CT/PET scans, MRIs)	20% coinsurance after ded	50% coinsurance after ded
Vision		
Pediatric eye exam[2] (1 visit per year)	Covered in full, ded waived	50% coinsurance after ded
Pediatric dental		
Dental checkup/preventive dental care[2] (2 visits per year)	Covered in full, ded waived	Paid at the designated level
Basic dental care	Not covered	Not covered
Pharmacy,***		
Pharmacy deductible	$250 ded per member; waived for Tiers T1A & T1†	$500 ded per member
Preferred generic drugs††	P: T1A - $3 copay/T1 - $10 copay NP: T1A - $15 copay/T1 - $15 copay	50% coinsurance after ded
Preferred brand drugs	P: $35 copay after ded NP: $45 copay after ded	50% coinsurance after ded
Non-Preferred drugs†††	P: $65 copay after ded NP: $80 copay after ded	50% coinsurance after ded
Specialty drugs‡	P: 30% coinsurance after ded NP: 50% coinsurance after ded	Not covered

*For important information on your costs and how out-of-network care is paid, read "Section 1 Using Your Benefits" in your Certificate of Coverage.

**If the physician prescribes or the member requests a covered brand name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent plus the applicable cost-sharing. The cost difference between the generic and brand does not count toward the out-of-pocket limit.

***Not all drugs are covered. It is important to look at the Drug List to understand which drugs are covered.

†T1A = Lower cost preferred generic drugs; T1 = Preferred generic drugs.

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