SALT LAKE COUNTY Medical Plan

Coverage Period: 04/01/2016 - 03/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual & Eligible Family | **Plan Type:** PPO

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 www.Regence.com or by calling 1 (866) 240-9580.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$2,000** single / **$4,000** family per plan year. Out-of-network: **$2,000** single / **$4,000** family per plan year. Doesn't apply to certain preventive care. Amounts in excess of the **allowed amount** do not count toward the **deductible**.	Single: You must pay all the costs up to the single **deductible** amount before this plan begins to pay for covered services you use. Family: Claimants collectively must pay all the costs up to the family **deductible** amount before this plan begins to pay for any claimant's covered services. The **deductible** starts over April 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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. In-network: **$3,500** single / **$7,000** family* per plan year. Out-of-network: **$8,000** single / **$16,000** family per plan year. *A claimant on family coverage will not have his or her **out-of-pocket** exceed $6,850.	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, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See **www.Regence.com** or call **1 (866) 240-9580** for lists of in-network or out-of-network **providers**.	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 don't need a referral to see a **specialist**.	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**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	SLCo HealthMe Clinic visits: $30 service fee, after deductible, $10 copay / visit; all other office visits: after deductible, $25 copay / visit, other services 10% coinsurance	After deductible, 30% coinsurance	————————none————————
	Specialist visit	After deductible, $35 copay / visit, other services 10% coinsurance	After deductible, 30% coinsurance	
	Other practitioner office visit	After deductible: $35 copay / visit for spinal manipulations, other services 10% coinsurance	No coverage	Coverage is limited to 10 spinal manipulations / claimant / plan year.
	Preventive care/ screening/immunization	No charge	No coverage	————————none————————
If you have a test	Diagnostic test (x-ray, blood work)	After deductible, 0% coinsurance	After deductible, 30% coinsurance	————————none————————
	Imaging (CT/PET scans, MRIs)	After deductible, 20% coinsurance	After deductible, 30% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Regence.com.	Generic drugs	After deductible, $10 co-pay / retail prescription After deductible, $20 co-pay / mail order prescription		Coverage is limited to 90-day supply from a retail or mail order supplier. Mail order **copayments** apply for 90-day supply retail. Coverage is limited to a 30-day supply for self-injectable medications from either retail or mail order supplier. No coverage for prescription drugs from an out-of-network pharmacy. **Deductible** does not apply to certain preventive drugs, women's contraceptives or immunizations at a participating pharmacy. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the **copayment** and/or **coinsurance**, unless your **provider** specifies "dispense as written." **Deductible** also waived for generic or preferred brand drugs specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List. The first fill of specialty drugs is allowed at a retail pharmacy; additional fills must be filled by a specialty pharmacy. Medications used as part of an outpatient cancer drug treatment regimen that is provided and dispensed in a professional setting will be subject to these prescription benefits.
	Preferred brand drugs	After deductible, 25% co-insurance (minimum $25 but not to exceed $75) / retail prescription After deductible, 25% co-insurance (minimum $50 but not to exceed $150) / mail order prescription		
	Non-preferred brand drugs	After deductible, 50% co-insurance (minimum of $50 but not to exceed $100) / retail prescription After deductible, 50% co-insurance (minimum $100 but not to exceed $200)/ mail order prescription		
	Specialty drugs	After deductible, 20% coinsurance up to $150 / generic specialty drug After deductible, 20% coinsurance up to $150 / brand-name specialty drug on the formulary After deductible, 20% coinsurance up to $150 / brand-name specialty drug not on the formulary		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	After deductible, 10% coinsurance	After deductible, 30% coinsurance	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Physician/surgeon fees	After deductible, 10% coinsurance	After deductible, 30% coinsurance	————————none————————
If you need immediate medical attention	Emergency room services	After deductible, $150 co-pay / visit	After in-network deductible, $150 co-pay / visit	————————none————————
	Emergency medical transportation	After deductible, 10% coinsurance	After in-network deductible, 10% coinsurance	————————none————————
	Urgent care	SLCo HealthMe Clinic visits: $30 service fee, after deductible, $10 copay / visit; all other urgent care office visits: after deductible, $45 co-pay / visit	After deductible, 30% coinsurance	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	After deductible, 10% coinsurance	After deductible, 30% coinsurance	————————none————————
	Physician/surgeon fee	After deductible, 10% coinsurance	After deductible, 30% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	After deductible, $35 copay for outpatient therapy visits	After deductible, 30% coinsurance	**Copayment** applies for each in-network **provider's** outpatient therapy visit only.
	Mental/Behavioral health inpatient services	After deductible, 10% coinsurance	After deductible, 30% coinsurance	
	Substance use disorder outpatient services	After deductible, $35 copay for outpatient therapy visits	After deductible, 30% coinsurance	
	Substance use disorder inpatient services	After deductible, 10% coinsurance	After deductible, 30% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	After deductible, 10% coinsurance	After deductible, 30% coinsurance	Adoption benefits limited to $4,000 / child placed for adoption up to age 17. The adoption indemnity benefit is not exchangeable for infertility treatment benefits.
	Delivery and all inpatient services	After deductible, 10% coinsurance	After deductible, 30% coinsurance	
If you need help recovering or have other special health needs	Autism services	After deductible, 10% coinsurance	No coverage	Coverage is limited to, $36,000 / claimant / plan year for children 0-9 years of age diagnosed with autism. Coverage is limited to $15,000 / claimant / plan year for children 10-18 years of age diagnosed with autism. Coverage is limited to 150 visits / claimant / plan year for physical, speech and occupational therapy for children 0-18 years of age diagnosed with autism.
	Home health care	After deductible, 0% coinsurance	After deductible, 30% coinsurance	Coverage is limited to 60 visits / claimant / plan year.
	Rehabilitation services	After deductible: $35 copay for outpatient visits, 10% coinsurance for inpatient services	After deductible, 30% coinsurance	Coverage is limited to 60 inpatient days / claimant / /plan year. Coverage is limited to 20 outpatient visits / claimant / plan year for physical therapy. Coverage is limited to 20 outpatient visits / claimant / plan year for occupational therapy. Coverage is limited to 60 outpatient visits / claimant / plan year for speech therapy.
	Habilitation services	After deductible, 10% coinsurance	After deductible, 30% coinsurance	Coverage for neurodevelopmental therapy is limited to 40 outpatient visits / claimant / plan year. Coverage for neurodevelopmental therapy is limited to services for claimants through age 6.
	Skilled nursing care	After deductible, 10% coinsurance	After deductible, 30% coinsurance	Coverage is limited to 60 inpatient days / claimant / plan year.
	Durable medical equipment	After deductible, 20% coinsurance	After deductible, 30% coinsurance	——————none——————
	Hospice service	After deductible, 0% coinsurance	After deductible, 30% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	Not covered	Not covered	——————none——————
	Glasses	Not covered	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Dental check-up	Not covered	Not covered	————————none————————

Excluded Services & Other Covered Services:

Exclusion Examples

The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under your plan, including related secondary medical conditions and are not inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications relating to services and supplies for, or in connection with, gastric or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for, or in connection with, reversal or revision of such procedures, or any direct complications or consequences thereof;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
  - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
  - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- complications that result from an injury or illness resulting from active participation in illegal activities.

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Vision hardware
- Weight loss programs except for nutritional counseling

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1 (866) 240-9580. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1 (877) 267-2323 x61565 or www.cciio.cms.gov.

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 the plan at 1 (866) 240-9580 or visit www.Regence.com. You may also contact your state insurance department at 1 (800) 439-3805 or www.insurance.utah.gov or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform.

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?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1 (866) 240-9580.

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 financial protection a sample patient might get if they are covered under 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** $4,860
- **Patient pays** $2,680

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**

Patient pays:

Deductibles	$2,000
Copays	$0
Coinsurance	$530
Limits or exclusions	$150
Total	**$2,680**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,030
- **Patient pays** $2,370

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$0
Coinsurance	$330
Limits or exclusions	$40
Total	**$2,370**

"Patient pays" amounts in this coverage example are based on Individual coverage. Different amounts may apply in Family coverage. Consult your plan documents for more information about your cost-sharing.

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.

Salt Lake County Vision Plan

Coverage Period: 04/01/2016 – 3/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs**Coverage for:** Individual & Eligible Family

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 www.Regence,com or by calling 1 (866) 240-9580.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** claimant / **$0** family per calendar year.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Does this plan use a network of providers?	Yes. See **www.Regence.com** or call 1 (866) 240-9580 for lists of in-network or out-of-network **providers**.	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 don't need a referral to see a specialist.	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 3. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered vision care, usually when you receive the service.
- **Coinsurance** 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 a vision examination is $50, your **coinsurance** payment of 20% would be $10. 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 provider charges $150 for a vision examination and the **allowed amount** is $50, you may have to pay the $100 difference. (This is called **balance billing**.)

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit an eye care provider's office or clinic	Vision examination	No charge	No charge	Coverage is limited to 1 eye exam per year.
	Vision hardware	Not covered	Not covered	

Excluded Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Contact fittings
- Cosmetic services and supplies
- Fees, taxes, interest
- Non-direct patient care
- Medical services
- Personal comfort items
- Prescription medication
- Vision hardware
- Vision therapy and surgery