Benefits Manager, Inc

Enrollment Instructions for Altius Health Plans

Here is a checklist of a few things that are commonly overlooked and are mandatory for processing your application.

- ❑ Print all pages of the application including instructions.
- ❑ Complete all questions and sections of the application in blue or black ink.

Don't forget to -

- ❑ Enter your required effective date. Remember you must submit to our office by the 25th of the month in order to qualify for your policy to be effective on the 1st of the following month.
- ❑ Select your preferred billing method.
- ❑ Sign and date the application.
- ❑ If you have requested that your monthly premium be deducted automatically from your checking account, you must sign and date the authorization form, attach a voided check to it, and include a check or money order payable to Altius Health Plans for the first month's premium.

Or

- ❑ If you have chosen 6-month prepayment include a check or money order payable to Altius Health Plans for the first six months' premium with the submission of the application.

- ❑ Mail completed, originally signed application and check if applicable to:

Benefits Manager, Inc
Attn: New Enrollment
1235 W. Stone Creek Ln.
Layton, UT 84041

As an example of one of many of our free services to our clients, Benefits Manager, Inc will review your application for completeness and accuracy before we submit it to Altius Health Plans for approval. This will greatly reduce the approval time because Altius Health Plans does not process unclear or incomplete applications until the missing information has been gathered.

After your application has been reviewed by Benefits Manager it will be submitted to *Altius Health Plans* for processing. If errors are found, please make any necessary charges and re-mail the corrected application to Benefits Manager for processing.

Please contact us if you have any questions regarding the application or enrollment process. You may reach us at (888)310-9623 or e-mail us at mikeoliphant@benefitsmanager.net.

Thank you for giving us this opportunity to serve you. We want to earn the right to have you as one of our Clients for Life.

The Benefits Manager Team

ALTIUS INDIVIDUAL HEALTH PLAN APPLICATION

10421 So. Jordan Gateway,
Suite 400
South Jordan, Utah 84095

Please complete this form in its entirety. Any false statements or omission of facts can result in denial of claims and cancellation or termination of your policy from the date of enrollment.

❑ Adding Dependent
❑ New Application
❑ Renewal with changes
Requested Effective Date: ____________________

I - APPLICANT INFORMATION

Name: Last:____________________________ First:______________________ MI:______ Occupation: ____________________________

Street Address:____ E-mail Address:____________________________

City:_____________________________ State:_____________ Zip Code:_____________ Home Phone: (_______) _____________________

Spouse's Occupation:____ Applicant's Daytime Phone: (______) ______________

Marital Status: ❑ Divorced ❑ Married ❑ Single ❑ Widowed

II - COVERAGE OPTIONS

❑ Peak (70%)
Deductible Option:
❑ $1,000
❑ $2,000

❑ Peak (80%)
Deductible Option:
❑ $0
❑ $250
❑ $500

❑ Peak Traditional (Ded first)
Deductible Option:
❑ $500
❑ $1,000
❑ $2,000

❑ Peak Advantage
❑ 10-15
❑ 20-20

IIa - PHARMACY DEDUCTIBLE OPTIONS

❑ No Deductible ❑ $500 Family Deductible ❑ $1,000 Family Deductible

III - MEMBERS TO BE ENROLLED

To be eligible for coverage, children must be under 26, unmarried, and dependent upon you for 50% of their support. (Financial dependency not required for court-ordered dependent coverage.) ANY DEPENDENT NOT LISTED WILL NOT BE CONSIDERED FOR COVERAGE.

Social Security Number	Indicate Relationship	Last Name	First Name	MI	Birth Date	Age	M	F	Other Coverage (Circle Y or N) Medical	Rx	Medicare
	Applicant								Y or N	Y or N	Y or N
									Y or N	Y or N	Y or N
									Y or N	Y or N	Y or N
									Y or N	Y or N	Y or N
									Y or N	Y or N	Y or N
									Y or N	Y or N	Y or N

IV - CURRENT & PRIOR INSURANCE COVERAGE

Do you or your dependent(s) have other health insurance? ❑ Yes ❑ No

If Yes: Name of Carrier: ______________________________ Phone #: (____)____________________ Policy #: ________________

Policy Holder's Name:____________________________ Effective Date of Coverage:____________ End Date:_________________

Name(s) of covered dependents: ____

If this coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that Altius can determine whose coverage is Primary.

If No: When was the last date that you were insured?: __________________________

If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must enclose proof of prior coverage, such as a Certificate of Creditable Coverage from your previous carrier.

◆ **Submission of prior coverage information does not automatically waive any Pre-Existing Condition Limitation. However, failure to provide proof of prior coverage will result in an automatic 12-month Pre-Existing Condition Waiting Period.**

For Office Use Only
Agent/Broker ____ Effective Date_______________ Tier_________ Premium___________
❑ 24 Hour
PEC____ Payment Option: ❑ Automatic withdrawal ❑ Monthly billing
____

V - HEALTH HISTORY

Instructions: Answer each question for each individual applying for coverage. Circle the specific item and check the appropriate box for each question. For each "Yes" answer, give complete and specific details in section VII.

Current Health

	Question	Yes	No
1.	Has anyone been under medical care in the last 12 months?	❑	❑
2.	Has anyone consulted, been tested, or had treatment by a doctor, chiropractor, counselor, therapist, or other health care provider within the past 3 years (including routine and wellness exams)?	❑	❑
3.	Is any family member currently pregnant or have reason to suspect that they might be pregnant?	❑	❑
4.	Are you or your spouse financially responsible for an unborn child, or do you anticipate adopting a child within the next 12 months?	❑	❑
5.	Does anyone have a problem for which they have not sought medical advice or treatment in the last 12 months?	❑	❑
6.	Do you have a spouse or dependent(s) who are not applying for coverage? If yes, complete (a) and (b) below.	❑	❑

a. List the reason(s) your spouse and/or dependents are not applying for coverage on this policy. ____________________________

____

b. Current health status of those not applying for coverage.________________

____

	Question	Yes	No
7.	Has anyone used tobacco in the last 12 months?	❑	❑
8.	Has anyone taken any medication, drugs, or shots in the past 12 months (including immunizations, birth control, etc.)? If yes, complete section VIII.	❑	❑

5-Year Health History

9. List below the height, current weight, and last year's weight for the applicant and spouse.

	Height	Current Weight	Last Year's Weight
APPLICANT:	_____ft _____in	________lbs	________lbs
SPOUSE:	_____ft _____in	________lbs	________lbs

10. Within the past 5 years, has any proposed insured been diagnosed, treated, or had any of the following conditions:

	Condition	Yes	No
a.	Advised to be hospitalized, have tests, have surgery or take medication, **but has not done so**?	❑	❑
b.	Gall bladder problems, ulcers, hernias, chronic diarrhea diverticulitis, diverticulosis, or other digestive problems?	❑	❑
c.	Urinary problems or urinary incontinence?	❑	❑
d.	Alcohol use, or attended Alcoholics Anonymous?	❑	❑
e.	Migraines, unconsciousness, dizziness, epilepsy, seizures, or convulsions?	❑	❑
f.	Mental health counseling, psychotherapy, had a mental or nervous disorder, depression, stress or anxiety that required consultation or medication?	❑	❑
g.	Cysts, growths (except warts), breast lump(s), breast augmentation or reduction?	❑	❑
h.	Skin disorder that required medical attention?	❑	❑
i.	Thyroid disorder, disorder of the lymph nodes, or lymph system?	❑	❑
j.	Chest pain, high blood pressure, or high cholesterol?	❑	❑
k.	Disorder of the eyes, ears, nose, or throat?	❑	❑
l.	Back, neck, spinal problems, or a joint disorder that required medical attention and/or interfered with daily functioning?	❑	❑

10-Year Health History

11. Within the past 10 years, has any proposed insured been diagnosed, treated, or had any of the following conditions:

	Condition	Yes	No
a.	Been hospitalized or had surgery?	❑	❑
b.	Hepatitis, colitis, rectal disease, spleen problems, jaundice or other digestive problems?	❑	❑
c.	Gout, arthritis, fibromyalgia, lupus, any connective tissue disease or disorder, or any joint replacement?	❑	❑
d.	Been diagnosed with, had treatment or surgery for, or any indication of, but not limited to the following: ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc(s), spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis?	❑	❑
e.	Obesity, bulimia, anorexia, medically supervised weight control, stomach stapling, or gastric bypass?	❑	❑
f.	Tuberculosis, asthma, sleep apnea, pleurisy, emphysema, or any disorder of the lungs or respiratory system?	❑	❑
g.	Irregular bleeding, abnormal pap smears, pelvic inflammatory disease, endometriosis, pelvic pain, prostate or testicular problems, venereal disease or any disorder of the reproductive system?	❑	❑
h.	Drug dependency, abuse of, or reaction to drugs?	❑	❑
i.	Been a user of any drug not prescribed, such as opiates, stimulants, depressants and/or hallucinogens?	❑	❑
j.	Bipolar disorder, manic depression, schizophrenia, chronic organic brain syndrome, or any other organic brain or psychotic disorders?	❑	❑

Life Health History

12. Has any proposed insured been diagnosed, treated, or had any of the following conditions within their lifetime:

	Condition	Yes	No
a.	Any birth defect, developmental or learning disability, physical, neurological or mental impairment(s)?	❑	❑
b.	Kidney disorder, liver problems, cirrhosis or pancreas problems?	❑	❑
c.	Cancer or tumors?	❑	❑
d.	Diabetes?	❑	❑
e.	Multiple sclerosis, muscular dystrophy, cerebral palsy, or any other neurological disorder?	❑	❑
f.	Any blood disorder, tested positive for Human Immunodeficiency Virus (HIV) or been treated for or been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any disease or disorder of the immune system?	❑	❑
g.	Any heart condition or problem, heart murmur, heart attack, rapid, slow, or irregular heartbeat, blood clot, stroke, or other circulatory problem?	❑	❑
h.	Fertility. Is anyone infertile, had miscarriages, or complications of pregnancy?	❑	❑

Miscellaneous Health History

	Question	Yes	No
13.	In the last 5 years, has anyone been unable to work or been unable to perform routine daily functions for more than 2 weeks (other than pregnancy)?	❑	❑
14.	Does anyone have any conditions, symptoms, or problems, in the last 10 years, not otherwise mentioned in connection with answering the questions above?	❑	❑
15.	To the best of your knowledge, has anyone been denied or turned down for other health or life insurance or been issued a modified or rated policy?	❑	❑

VI - RESIDENCY

Do any of the proposed insureds live, reside, work, or attend school outside the state of Utah at any time of the year? ❑ Yes* ❑ No

*If Yes, please explain: ____

VII - ADDITIONAL INFORMATION

For every "yes" answer in the health history section, complete the following information:

Question #	First name of individual receiving treatment	Diagnosis of illness, injury, treatment, testing, or medical attention	Start date mo/day/yr	End date mo/day/yr	Remaining symptoms or problems	Name of physician or hospital

VIII - PRESCRIPTION MEDICATION INFORMATION

First name of individual	Name of medication	Dosage	Start date mo/day/yr	End date mo/day/yr	Reason for medication	Name of prescribing physician

IX - 24-HOUR COVERAGE

❑ Yes ❑ No

Note: 24-Hour Coverage is available only for owners, partners, or sole proprietors who are not required by law to be covered under employer liability coverage (workers' compensation insurance). 24-Hour Coverage is an additional cost of $25 per month.

Note: Your employer cannot pay for any portion of the policy premium, either directly or through reimbursement.

X - AUTHORIZATION & ACKNOWLEDGEMENT

I hereby apply for coverage with Altius Health Plans (Altius) for the persons listed on this application (collectively referred to as Applicants). When incorporated with the policy, this application and the medical benefits brochure become part of the policy. Once fully signed and executed, Altius and I agree to the terms set forth in the policy. I understand that coverage is dependent upon my satisfaction of applicable underwriting criteria. I also understand that no coverage will be in force until each person listed above is approved by Altius, that no benefits will be provided for any services which begin before the coverage is effective, and that benefits will not extend beyond the termination of either my coverage or the policy.

CONSENT AT ENROLLMENT: I authorize 1) all health providers and insurers to furnish Altius, and 2) all health providers and Altius to furnish all insurers and health providers records concerning Applicants for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative may receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through Altius. For purposes of collecting information for an insurance policy application, policy reinstatement, or a request for change in policy benefits, this authorization shall remain valid for 30 months from the date the authorization is signed.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the Health information in Sections V-VIII of this application is correctly recorded, true and complete. I understand that material omissions or misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or could void any coverage issued. If I subsequently become aware of information different from that provided in this application, I agree to provide that additional information promptly to Altius Health Plans. I understand that no agent or Altius representative is allowed to permit me to answer any questions inaccurately, untruthfully or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to Altius changes in the eligibility of any Applicants who become members.

By signing this application, I agree on behalf of all Applicants that Altius may use or disclose to third parties the information contained on this application and individually identifiable health information relating to the Applicants for purposes of administering my health insurance benefits including treatment, payment, or health care operations, as those terms are explained in detail in the Altius Notice of Privacy Practices and to the extent permitted by law. My consent includes agreement for the use or disclosure of health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV). By signing this form, I also agree on behalf of myself and the other Applicants, to the extent permitted by law, health care providers, insurers, claims administrators, employers, and others may disclose the Applicants' personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness including substance abuse, AIDS, ARC, or HIV to Altius for administration of health insurance benefits including treatment, payment, or health care operations purposes and other purposes permitted by law.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE:
According to information you have furnished, you may intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Altius. Your new policy provides 10 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions that you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in a denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history.
4. Failure to include all material medical information on an application may provide a basis for Altius to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

I understand the coverage for which I am applying excludes certain conditions/procedures for twelve months, regardless of whether or not they are pre-existing. I also understand that the coverage may limit or exclude conditions for which a family member or I have received, or have been recommended to receive, any medical advice, diagnosis, care, or treatment during the six months immediately preceding the coverage effective date, according to the pre-existing conditions limitations provisions of the policy. I understand that this application will become part of the policy.

XI - SIGNATURE

I have read and agree to the statements above.

Signature: ____ Date Signed: _________________________

XII - PAYMENT OPTION

Is any employer reimbursing or paying for any portion of this plan? ❑ Yes ❑ No

Are you self-employed? ❑ Yes ❑ No

If self-employed, do you have any part- or full-time empoyees? ❑ Yes ❑ No

Method of Payment

Please choose one of the following premium payment options:

❑ **Monthly Automatic Withdrawal (complete Section XIII)**

❑ **Monthly Billing (a $5 administrative fee will be added to your monthly billing statement)**
You will receive a monthly billing statement by mail. Payment is due on the first day of each month.

A $25 service charge will be assessed if your check is returned or we cannot deduct the premium amount from your account due to insufficient funds.

Your first payment is due when your application is approved. The premium payment method you select will begin with your second month's premium.

XIII - MONTHLY AUTOMATIC WITHDRAWAL

If you choose to pay by monthly automatic withdrawal, please attach your voided check or savings deposit slip here. Please complete the following:

I (we) authorize Altius Health Plans to initiate debit entries to my (our) ❑ Checking Account ❑ Savings Account

I (we) understand that debit entries will be submitted to my (our) account on or about the 10th of each month, regardless of my (our) Policy's effective date.

Account Holder's Signature: ______________________________ Date: ____________________

MONTHLY AUTOMATIC WITHDRAWAL

PLEASE ATTACH A VOIDED CHECK OR VOIDED SAVINGS DEPOSIT SLIP HERE

Do not use a deposit slip for a checking withdrawal.
Checking deposit slips do not always contain the necessary routing information.

Important Note:

Coverage is not in effect until Altius Health Plans approves your application and determines an effective date. **We strongly suggest that you carefully consider the impact of changing coverage, and do not cancel any current coverage until you are officially notified by Altius Health Plans Inc. of approval.** We reserve the right to reject coverage for any individual.

XIV - AGENT/BROKER AGREEMENT

I understand and agree that in acting as the agent/broker for this applicant:

1. The application was completed by the applicant.
2. I am in possession of a valid license issued by the State of Utah authorizing me to sell and service health insurance contracts.
3. I must be an Altius-appointed broker or agent to sell Altius Individual Health Plans.
4. I have no authority to do the following: make, alter, interpret, or change an application or contract in the name of Altius Health Plans Inc.; or waive any of the terms or conditions of the contract.
5. I have no authority to assign effective dates or to effect membership changes.
6. Cancellation of this Health Care Agreement by either the subscriber or Altius Health Plans Inc. will terminate the Agency Agreement.

Agent/Broker Name: ______________________________________ Agency: _____________________________

Phone Number: (______) _______________ Date Signed: ____

Fax Number: (______) ________________

Agent/Broker Signature: ____

If you do not have an agent, please sign below and one will be assigned to you.

Applicant Signature: _____________________________________ **Date:** _______________________________

XV - CHECKLIST

Send the following completed forms:

❏ Application

❏ Certificate of Creditable Coverage (This certificate is provided by your previous health insurance carrier and must be submitted to receive credit for your Pre-Existing Condition Waiting Period. If you are currently covered with Altius Health Plans, this is not necessary.)

❏ Voided check for Monthly Automatic Withdrawal option

❏ Signature on Section XI

You may submit your application to Altius through your Altius-appointed agent or broker, or directly to Altius Health Plans at the following address:

Altius Health Plans
Underwriting Department — Individual Health Plans
10421 South Jordan Gateway, Suite 400
South Jordan, UT 84095

www.altiushealthplans.com

I Plan Comparison Benefits Summary

	Peak 80% Plan Open Access Plan	Peak 70% Plan Open Access Plan	Peak Traditional Open Access Plan
	Participating Providers Only	**Participating Providers Only**	**Participating Providers Only**
Calendar Deductible – Individual/Family Does not apply to OOP Max	☐ $0 / $0 ☐ $250 / $500 ☐ $500 / $1,000	☐ $1,000 / $2,000 ☐ $2,000 / $4,000	☐ $500 / $1,000 ☐ $1,000 / $2,000 ☐ $2,000 / $4,000
Out-of-Pocket Maximum – Individual/Family	$2,000 Individual / $4,000 Family	$3,500 Individual / $7,000 Family	$2,000 Individual / $4,000 Family
Annual Benefit Maximum	None	None	None
Lifetime Maximum*	$2 Million	$2 Million	$2 Million
Pre-Existing Condition Limitation	12 Months	12 Months	12 Months
Outpatient Services	**You Pay**	**You Pay**	**You Pay**
Office Visits – Primary/Preventive Care, Eye Exams	$15	$25	$20 AD
Office Visits – Specialists	$25	$35	$30 AD
After Hours & Urgent Care	$25	$35	$30 AD
Chiropractic Care – 10 visits per member/calendar year	$25	$35	$30 AD
Major Lab/Radiology	20% AD	30% AD	20% AD
Minor Lab/X-ray (including mammograms)	You Pay Nothing	You Pay Nothing	You Pay Nothing AD
Physiotherapy at Provider's Office – 10 total provider/facility visits per type, per member/calendar year	$25	$35	$30 AD
Physiotherapy at Facility – 10 total provider/facility visits per type, per member/calendar year	20% AD	30% AD	20% AD
Emergency Care	**You Pay**	**You Pay**	**You Pay**
Emergency Room Care	$75 Participating / $150 Non-participating	$100 Participating / $200 Non-participating	$100 AD Participating / $200 AD Non-participating
Urgent Care	$25	$35	$30 AD
Ambulance	20% AD	30% AD	20% AD
Inpatient/Outpatient Hospital	**You Pay**	**You Pay**	**You Pay**
Inpatient Hospital / Facility Services	20% AD	30% AD	20% AD
Outpatient Hospital / Facility Services	20% AD	30% AD	20% AD
Additional Professional Services – Billed by facility	20% AD	30% AD	20% AD
Additional Professional Services – Billed by professional	20% AD	30% AD	20% AD
Inpatient / Outpatient Physician, Surgeon, Assistant Surgeon	20% AD	30% AD	20% AD
Organ Transplant Services	20% AD	30% AD	20% AD
Maternity Services (Subscriber/Spouse Only)	**You Pay**	**You Pay**	**You Pay**
Deductible	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
Pre-Natal and Post-Natal Care	100% Coverage After Maternity Deductible	100% Coverage After Maternity Deductible	100% Coverage After Maternity Deductible
Inpatient Hospital / Facility Services	100% Coverage After Maternity Deductible	100% Coverage After Maternity Deductible	100% Coverage After Maternity Deductible

- Deductibles, Lifetime Maximums, and Out-of-Pocket Maximums are cumulative across all levels.
- Deductibles, fixed dollar copays, and certain services DO NOT apply to the Out-of-Pocket Maximum.

* Lifetime Maximum for Peak Advantage is limited to a combined maximum of $2 Million across all levels.
AD = After Deductible

Peak Advantage

Open Access Plan

I-PA 10 / 15

Level 1	Level 2	Level 3
Participating Providers Only		
$250 Individual / $500 Family	$500 Individual / $1,000 Family	$1,000 Individual / $2,000 Family
$1,000 Individual / $2,000 Family	$2,000 Individual / $4,000 Family	$3,000 Individual / $6,000 Family
None	None	None
$2 Million		
12 Months		
You Pay		
$15	$25	$35
$15	$25	$35
$25	$35	$45
$25		
10% AD	20% AD	30% AD
You Pay Nothing		
$15	$25	$35
10% AD	20% AD	30% AD
You Pay		
$75 Level 2 / $100 Level 3 / $150 Non-participating		
$25	$35	$45
20% After Level 2 Deductible		
You Pay		
→	20% AD	30% AD
→	20% AD	30% AD
→	20% AD	30% AD
20% After Level 2 Deductible		
10% AD	20% AD	30% AD
→	20% AD	30% AD
You Pay		
Maternity benefits have a **SEPARATE $7,500 Deductible** per occurrence		
100% coverage after Maternity Deductible		
100% coverage after Maternity Deductible		

I-PA 20 / 20

Level 1	Level 2	Level 3
Participating Providers Only		
$250 Individual / $500 Family	$500 Individual / $1,000 Family	$1,000 Individual / $2,000 Family
$2,000 Individual / $4,000 Family	$3,000 Individual / $6,000 Family	$4,000 Individual / $8,000 Family
None	None	None
$2 Million		
12 Months		
You Pay		
$20	$30	$40
$20	$30	$40
$30	$40	$50
$30		
20% AD	30% AD	40% AD
You Pay Nothing		
$20	$30	$40
20% AD	30% AD	40% AD
You Pay		
$100 Level 2 / $150 Level 3 / $200 Non-participating		
$30	$40	$50
30% After Level 2 Deductible		
You Pay		
→	30% AD	40% AD
→	30% AD	40% AD
→	30% AD	40% AD
30% After Level 2 Deductible		
20% AD	30% AD	40% AD
→	30% AD	40% AD
You Pay		
Maternity benefits have a **SEPARATE $7,500 Deductible** per occurrence		
100% coverage after Maternity Deductible		
100% coverage after Maternity Deductible		

- 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.

I Plan Comparison Benefits Summary
–Continued–

	Peak 80% Plan Open Access Plan	Peak 70% Plan Open Access Plan	Peak Traditional Open Access Plan
	Participating Providers Only	Participating Providers Only	Participating Providers Only
Prescription Drugs✦	**You Pay**	**You Pay**	**You Pay**
Pharmacy Deductible	☐ No Deductible ☐ $500 Family ☐ $1,000 Family	☐ No Deductible ☐ $500 Family ☐ $1,000 Family	☐ No Deductible ☐ $500 Family ☐ $1,000 Family
Prescription Drugs – 30 day supply (Preferred Generic / Preferred Brand / Non-Preferred)	$15 / $30 / $60 After Pharmacy Deductible	$15 / $30 / $60 After Pharmacy Deductible	$15 / $30 / 50% w/ $60 Non-preferred minimum After Pharmacy Deductible
Injectable Medications	**You Pay**	**You Pay**	**You Pay**
Injectable Medications – Facility	20% AD	30% AD	20% AD
Injectable Medications – Non-Facility (Preferred / Non-Preferred)	20% / 30%	30% / 40%	20% / 30%
Injectable Medications – Pharmacy (Preferred / Non-Preferred)	20% / 30%	30% / 40%	20% / 30%
Allergy Conditions	**You Pay**	**You Pay**	**You Pay**
Testing & Treatment	$25	$35	$30 AD
Serum	20% AD	30% AD	20% AD
Injections	You Pay Nothing	You Pay Nothing	You Pay Nothing AD
Other Benefits	**You Pay**	**You Pay**	**You Pay**
Accident Related Dental Services – $1,000 lifetime maximum	50% AD	50% AD	50% AD
Durable Medical Equipment (DME) – $5,000 per member/calendar year	20%	30%	20% AD
Home Health Care - 30 visits per member/calendar year	20% AD	30% AD	20% AD
Home Hospice	20% AD	30% AD	20% AD
Implantable Contraceptives and Intra-Uterine Devices (IUDs)	20%	30%	20% AD
Infertility Services – Evaluation, testing, and diagnostic services; $750 per member/calendar year, up to a lifetime maximum of $5,000	50% AD	50% AD	50% AD
Medical Supplies	20%	30%	20% AD
Neuropsychological Testing	50% AD	50% AD	50% AD
Skilled Nursing Facility – 30 days per member/calendar year	20% AD	30% AD	20% AD
Sterilization Procedures – Physician's office	$25	$35	$30 AD
Sterilization Procedures – Outpatient facility	20% AD	30% AD	20% AD
Temporomandibular Joint Dysfunction (TMJ) – Evaluation, testing and diagnostic services; lifetime maximum of $1,000	50% AD	50% AD	50% AD
Mental Health and Substance Abuse	No Coverage	No Coverage	No Coverage

- Deductibles, Lifetime Maximums, and Out-of-Pocket Maximums are cumulative across all levels.
- Deductibles, fixed dollar copays, and certain services DO NOT apply to the Out-of-Pocket Maximum.

✦ 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, any applicable deductible, and/or the generic copay. Regular benefits apply if a preferred generic cannot be substituted.
AD = After Deductible

Peak Advantage

Open Access Plan

I-PA 10 / 15			I-PA 20 / 20		
Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
Participating Providers Only			Participating Providers Only		
You Pay			**You Pay**		
☐ No Deductible ☐ $500 Family ☐ $1,000 Family			☐ No Deductible ☐ $500 Family ☐ $1,000 Family		
$15 / $30 / $60 After Pharmacy Deductible			$15 / $30 / $60 After Pharmacy Deductible		
You Pay			**You Pay**		
Facility Benefit Level			Facility Benefit Level		
20% / 30%			30% / 40%		
20% / 30%			30% / 40%		
You Pay			**You Pay**		
$15	$25	$35	$20	$30	$40
20%			30%		
You Pay Nothing			You Pay Nothing		
You Pay			**You Pay**		
50% After Level 2 Deductible			50% After Level 2 Deductible		
20%			30%		
10% AD	20% AD	30% AD	20% AD	30% AD	40% AD
10% AD	20% AD	30% AD	20% AD	30% AD	40% AD
20%			30%		
50% AD	50% AD	60% AD	50% AD	50% AD	60% AD
20%			30%		
50% After Level 2 Deductible			50% After Level 2 Deductible		
10% AD	20% AD	30% AD	20% AD	30% AD	40% AD
$15	$25	$35	$20	$30	$40
⇨	20% AD	30% AD	⇨	30% AD	40% AD
50% After Level 2 Deductible			50% After Level 2 Deductible		
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.