Employee Benefit Plan/Value Plan Option:VTB6H **Coverage Period:** 1/1/2016-12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee, Spouse, 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.talltreehealth.com or by calling 1-877-453-4201

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Participating providers, $6,350 person; $12,700 family; Non Par providers, $12,700 person; $25,400 family; Does not apply to preventive care/Co-pays.	For the services applicable, you must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your plan document to see when the deductible starts over (usually, but not always, January 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. For Participating providers $6,350 person/$12,700 family. For Non Par providers $25,400 person/$50,800 family	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, Prescription Drugs, balance-billed charges, health care this plan does not cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.talltreehealth.com or call 1-877-453-4201 for a list of participating 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 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 the 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 plan document.

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- **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 participating **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	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Specialist visit	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Other practitioner office visit	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Preventive care/screening/immunization	Plan pays 100%	No Benefit	
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Imaging (CT/PET scans, MRIs)	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.

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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.[insert].	Generic drugs	Deductible, then Plan pays 100%, both retail and mail order	No Benefit	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	Deductible, then Plan pays 100%, both retail and mail order	No Benefit	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	Deductible, then Plan pays 100%, both retail and mail order	No Benefit	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Specialty drugs	Deductible, then Plan pays 100%	No Benefit	Covers 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Physician/surgeon fees	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
If you need immediate medical attention	Emergency room services	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Based on plan provisions
	Emergency medical transportation	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Urgent care	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.

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 have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Physician/surgeon fee	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Mental/Behavioral health inpatient services	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Substance use disorder outpatient services	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Substance use disorder inpatient services	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
If you are pregnant	Prenatal and postnatal care	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Delivery and all inpatient services	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.

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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 help recovering or have other special health needs	Home health care	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Rehabilitation services	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Habilitation services	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Skilled nursing care	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Durable medical equipment	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
	Hospice service	Deductible, then Plan pays 100%	Deductible, then 50% co-insurance	Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed.
If your child needs dental or eye care	Eye exam	Plan covers 100%	No Covered	Based on plan provisions
	Glasses	Not covered	Not covered	Based on plan provisions
	Dental check-up	Not covered	Not covered	Based on plan provisions

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Excluded Services & Other Covered Services:

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
- Dental care (Adults)
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. if travel is for sole purpose of obtaining medical services
- Routine Foot care
- Weight Loss programs

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
- Private-duty nursing
- Urgent Care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstance, 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 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 877-453-4201. 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, extension 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

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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:

Tall Tree Administrators
P.O. Box 71747
Salt Lake City, Utah 84171-0747
1-877-453-4201

Department of Labor Employee Benefits Security Administration

1-866-444-EBSA (3272)

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?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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Employee Benefit Plan/Value Plan Option:VTB6H **Coverage Period:** 01/01/2016-12/31/2016

Coverage Examples **Coverage for:** Employee, Spouse and Family **Plan Type:** PPO

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** $2,190
- **Patient pays** $5,350

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	$5,200
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$5,350**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $50
- **Patient pays** $5,350

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	$5,270
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5,350**

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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 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.

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