



## HMO/Plus Benefit Summary

This table is for comparison purposes only and does not replace the Member Payment Summary. Please refer to the Contract and Member Payment Summary that you will receive upon approval of your application for detailed benefit information.

| BENEFITS  | PARTICIPATING BENEFITS<br><i>HMO &amp; Plus plans</i> |   |                         |                            | NONPARTICIPATING BENEFITS<br><i>Plus plans only</i> |   |   |
|---|---|---|-------------------------|----------------------------|---|---|---|
|   | Medical Deductible<br>Single/Family                   | Medical Out-of-Pocket<br>Single/Family  | Rx Deductible<br>Single | Rx Out-of-Pocket<br>Single | Medical Deductible<br>Single/Family                 | Medical Out-of-Pocket<br>Single/Family  | Rx Deductible & Out-of-Pocket<br>Single |
| <b>DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM OPTIONS</b>   |   |   |                         |                            |   |   |   |
| Deductible included in the out-of-pocket maximum  | \$250/\$750   | \$2,500/\$5,000   | \$100 <sup>2</sup>      | \$4,000                    | \$500/\$1,500                                       | \$4,500/\$9,000   | See "Participating Benefits"            |
|   | \$500/\$1,500   | \$3,000/\$6,000   | \$200 <sup>2</sup>      | \$4,000                    | \$750/\$2,250                                       | \$5,000/\$10,000  | See "Participating Benefits"            |
|   | \$1,000/\$2,500                                       | \$3,500/\$7,000   | \$400 <sup>2</sup>      | \$4,000                    | \$1,500/\$3,500                                     | \$5,500/\$11,000  | See "Participating Benefits"            |
|   | \$2,500/\$5,000                                       | \$4,000/\$8,000   | \$1,000 <sup>2</sup>    | \$4,000                    | \$3,000/\$6,000                                     | \$6,000/\$12,000  | See "Participating Benefits"            |
| <b>COINSURANCE AND COPAY OPTIONS</b>  |   |   |                         |                            |   |   |   |
| <b>80/20 Coinsurance Option</b>   |   |   |                         |                            |   |   |   |
| Coinsurance (e.g., inpatient, outpatient) <sup>4</sup>  |   | 20% after deductible  |                         |                            |   | 40% after deductible  |   |
| Office Visit (PCP/SCP) <sup>3</sup>   |   | \$15/\$25 after deductible <sup>1</sup>   |                         |                            |   | 40% after deductible  |   |
| Participating Emergency Room Visit  |   | \$100 after deductible  |                         |                            |   | See "Participating Benefits"  |   |
| Nonparticipating Emergency Room Visit   |   | \$200 after deductible  |                         |                            |   | See "Participating Benefits"  |   |
| <b>70/30 Coinsurance Option</b>   |   |   |                         |                            |   |   |   |
| Coinsurance (e.g., inpatient, outpatient) <sup>4</sup>  |   | 30% after deductible  |                         |                            |   | 50% after deductible  |   |
| Office Visit (PCP/SCP) <sup>3</sup>   |   | \$25/\$35 after deductible <sup>1</sup>   |                         |                            |   | 50% after deductible  |   |
| Participating Emergency Room Visit  |   | \$125 after deductible  |                         |                            |   | See "Participating Benefits"  |   |
| Nonparticipating Emergency Room Visit   |   | \$250 after deductible  |                         |                            |   | See "Participating Benefits"  |   |
| <b>STANDARD BENEFITS</b>  |   |   |                         |                            |   |   |   |
| <b>Lifetime Maximum Plan Payment</b>  | \$2,500,000   |   |                         |                            | \$1,000,000   |   |   |
| <b>Maximum Annual Out-of-Network Payment</b>  | N/A   |   |                         |                            | \$500,000   |   |   |
| <b>Pre-Existing Conditions</b>  |   |   |                         |                            |   |   |   |
| Waived (entirely or partly) for qualifying pre-existing condition credit  |   | Not covered for first 12 months   |                         |                            |   | Not covered for first 12 months   |   |
| <b>Professional Services</b>  |   |   |                         |                            |   |   |   |
| Adult and Pediatric Immunizations   |   | Covered 100%  |                         |                            |   | Not covered   |   |
| Elective Immunizations  |   | Participating coinsurance   |                         |                            |   | Not covered   |   |
| <b>Outpatient Services</b>  |   |   |                         |                            |   |   |   |
| Intermountain InstaCare <sup>SM</sup> /Urgent Care  |   | SCP copay amount, after deductible <sup>1</sup>   |                         |                            |   | Nonparticipating coinsurance, after deductible  |   |
| Intermountain KidsCare <sup>SM</sup>  |   | PCP copay amount, after deductible <sup>1</sup>   |                         |                            |   | Not applicable  |   |
| Diagnostic Tests, Minor   |   | Covered 100%, after deductible <sup>1</sup>   |                         |                            |   | Nonparticipating coinsurance, after deductible  |   |
| Diagnostic Tests, Major   |   | Participating coinsurance, after deductible   |                         |                            |   | Nonparticipating coinsurance, after deductible  |   |
| Physical, Speech, and Occupational Therapy<br>20 visits per calendar year   |   | SCP copay amount, after deductible  |                         |                            |   | Nonparticipating coinsurance, after deductible  |   |
| <b>Mental Health and Chemical Dependency</b>  |   |   |                         |                            |   |   |   |
| Not applied to the out-of-pocket maximum  |   | 50% after deductible  |                         |                            |   | 50% after deductible  |   |
| Inpatient limited to 10 days/calendar year  |   |   |                         |                            |   |   |   |
| Outpatient limited to 25 visits/calendar year   |   |   |                         |                            |   |   |   |
| <b>Supplemental Accident</b> (per person/calendar year)   |   |   |                         |                            |   | First \$1,000 covered at 100%   |   |
| <b>Miscellaneous Services</b>   |   |   |                         |                            |   |   |   |
| Maternity and Adoption (not applied to out-of-pocket)   |   | Covered at 100%, after \$5,000 calendar year maternity deductible   |                         |                            |   | Not covered   |   |
| Infertility (limited to \$1,500/calendar year; \$5,000/lifetime)  |   | 50% after deductible  |                         |                            |   | Not covered   |   |
| Chiropractic  |   | Not covered   |                         |                            |   | Not covered   |   |
| <b>Prescription Drugs</b>   |   |   |                         |                            |   |   |   |
| Up to a 30-day supply for covered medications; generic substitution required; same benefit applies to 90-day maintenance home delivery supply |   | Tier 1: \$10 after Rx deductible <sup>2</sup><br>Tier 2: 25% after Rx deductible <sup>2</sup><br>Tier 3: 50% after Rx deductible <sup>2</sup> |                         |                            |   | Tier 1: \$10 after Rx deductible <sup>2</sup><br>Tier 2: 25% after Rx deductible <sup>2</sup><br>Tier 3: 50% after Rx deductible <sup>2</sup> |   |

### BENEFIT SUMMARY FOOTNOTES:

1. Medical deductible waived when you select a mid- or high-level plan.
2. Rx deductible also waived when you select a high-level plan.
3. PCP (Primary Care Provider); SCP (Secondary Care Provider).
4. Coinsurance applies to inpatient and outpatient services, ambulance, home health, durable medical equipment, injectable drugs, and allergy treatment.