



## Selecting an HMO/Plus Plan

Follow these simple steps to create the HMO/Plus plan that's right for you:

### STEP 1. SELECT YOUR PROVIDER NETWORK *(see page 4 for detailed descriptions)*

 **select:value.**

 **select:med<sup>+</sup>**

 **select:care<sup>+</sup>**

#### NOTE:

If you choose the Select Med or Select Care networks, your plan automatically has a point-of-service feature otherwise known as a 'Plus' plan. This means you can use both participating and nonparticipating providers. Please refer to the Benefit Summary on the following page for benefit details.

### STEP 2. SELECT YOUR PLAN LEVEL

**Base-Level Plan:** The medical and Rx deductible applies to all services. Available medical deductibles under this option are \$250, \$500, \$1,000, and \$2,500. Each medical deductible has a separate Rx deductible.

**Mid-Level Plan:** The mid-level plan offers the same coverage as the base-level plan with one enhancement: the deductible waiver option. This means the medical deductible is waived for participating provider office visits, Intermountain InstaCare<sup>SM</sup>/urgent care visits, Intermountain KidsCare<sup>SM</sup> visits, or Intermountain ExpressCare<sup>SM</sup> visits. Available medical deductibles under this option are \$250 and \$500. Each medical deductible has a separate Rx deductible.

**High-Level Plan:** The high-level plan includes the medical deductible waiver as well as Rx deductible waiver. Available medical deductibles under this option are \$250, \$500, and \$1,000.

### STEP 3. SELECT YOUR ANNUAL DEDUCTIBLES AND CORRESPONDING OUT-OF-POCKET MAXIMUMS

Deductibles are based on a calendar year. The deductible applies to all services before any copay or coinsurance applies, unless you select a mid- or high-level plan. Be sure that the deductible you select is listed as available for your benefit level. Out-of-pocket maximums include your annual deductible amount.

\$250 deductible (available with base-, mid- or high-level plans)

\$500 deductible (available with base-, mid- or high-level plans)

\$1,000 deductible (available with base- or high-level plans)

\$2,500 deductible (available with base-level plan)

### STEP 4. SELECT YOUR COINSURANCE/COPAY AMOUNT

20% coinsurance, \$15/\$25 copay

30% coinsurance, \$25/\$35 copay

### STEP 5. CALCULATE YOUR PREMIUM

Now that you have created your plan, use the HMO Premium Calculation Worksheet on page 7 to calculate your monthly premium. Begin by turning to the rate page listing the coinsurance option and plan level you have selected. Next, refer to your provider network and deductible. Your rate will be based on the age of the applicant (oldest family member applying for coverage) and your coverage tier (single, two-party, or family).



## 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.

| DEDUCTIBLE AND OUT-OF-POCKET<br>MAXIMUM OPTIONS  | PARTICIPATING BENEFITS<br><i>HMO &amp; Plus plans</i>   |   |                            |                               | NONPARTICIPATING BENEFITS<br><i>Plus plans only</i>   |   |  |
|--|---|---|----------------------------|-------------------------------|---|---|--|
|  | Medical<br>Deductible<br>Single/Family  | Medical<br>Out-of-Pocket<br>Single/Family | Rx<br>Deductible<br>Single | Rx<br>Out-of-Pocket<br>Single | Medical<br>Deductible<br>Single/Family  | Medical<br>Out-of-Pocket<br>Single/Family | Rx Deductible &<br>Out-of-Pocket<br>Single |
| 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  |   |  |
| Intermountain ExpressCare <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 \$1500/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 | 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> |   |  |

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.