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 *HMO & Plus plans*				NONPARTICIPATING BENEFITS *Plus plans only*		
DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM OPTIONS Deductible included in the out-of-pocket maximum	**Medical Deductible Single/Family**	**Medical Out-of-Pocket Single/Family**	**Rx Deductible Single**	**Rx Out-of-Pocket Single**	**Medical Deductible Single/Family**	**Medical Out-of-Pocket Single/Family**	**Rx Deductible & Out-of-Pocket Single**
	$250/$750	$2,500/$5,000	$100[2]	$4,000	$500/$1,500	$4,500/$9,000	See "Participating Benefits"
	$500/$1,500	$3,000/$6,000	$200[2]	$4,000	$750/$2,250	$5,000/$10,000	See "Participating Benefits"
	$1,000/$2,500	$3,500/$7,000	$400[2]	$4,000	$1,500/$3,500	$5,500/$11,000	See "Participating Benefits"
	$2,500/$5,000	$4,000/$8,000	$1,000[2]	$4,000	$3,000/$6,000	$6,000/$12,000	See "Participating Benefits"

BENEFITS	PARTICIPATING BENEFITS	NONPARTICIPATING BENEFITS
COINSURANCE AND COPAY OPTIONS		
80/20 Coinsurance Option		
Coinsurance (e.g., inpatient, outpatient)[4]	20% after deductible	40% after deductible
Office Visit (PCP/SCP)[3]	$15/$25 after deductible[1]	40% after deductible
Participating Emergency Room Visit	$100 after deductible	See "Participating Benefits"
Nonparticipating Emergency Room Visit	$200 after deductible	See "Participating Benefits"
70/30 Coinsurance Option		
Coinsurance (e.g., inpatient, outpatient)[4]	30% after deductible	50% after deductible
Office Visit (PCP/SCP)[3]	$25/$35 after deductible[1]	50% after deductible
Participating Emergency Room Visit	$125 after deductible	See "Participating Benefits"
Nonparticipating Emergency Room Visit	$250 after deductible	See "Participating Benefits"
STANDARD BENEFITS		
Lifetime Maximum Plan Payment	$2,500,000	$1,000,000
Maximum Annual Out-of-Network Payment	N/A	$500,000
Pre-Existing Conditions		
Waived (entirely or partly) for qualifying pre-existing condition credit	Not covered for first 12 months	Not covered for first 12 months
Professional Services		
Adult and Pediatric Immunizations	Covered 100%	Not covered
Elective Immunizations	Participating coinsurance	Not covered
Outpatient Services		
Intermountain InstaCare℠/Urgent Care	SCP copay amount, after deductible[1]	Nonparticipating coinsurance, after deductible
Intermountain KidsCare℠	PCP copay amount, after deductible[1]	Not applicable
Diagnostic Tests, Minor	Covered 100%, after deductible[1]	Nonparticipating coinsurance, after deductible
Diagnostic Tests, Major	Participating coinsurance, after deductible	Nonparticipating coinsurance, after deductible
Physical, Speech, and Occupational Therapy 20 visits per calendar year	SCP copay amount, after deductible	Nonparticipating coinsurance, after deductible
Mental Health and Chemical Dependency		
Not applied to the out-of-pocket maximum Inpatient limited to 10 days/calendar year Outpatient limited to 25 visits/calendar year	50% after deductible	50% after deductible
Supplemental Accident (per person/calendar year)	First $1,000 covered at 100%	
Miscellaneous Services		
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
Prescription Drugs		
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[2] Tier 2: 25% after Rx deductible[2] Tier 3: 50% after Rx deductible[2]	Tier 1: $10 after Rx deductible[2] Tier 2: 25% after Rx deductible[2] Tier 3: 50% after Rx deductible[2]

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.