HealthSave Benefit Summary – 80%/20% Coinsurance Plans

This table is for comparison purposes only and does not replace the Member Payment Summary. Please refer to the Contract and Member Payment Summary for detailed benefit information.

BENEFITS	PARTICIPATING BENEFITS *HMO & Plus plans*	NONPARTICIPATING BENEFITS[1,2] *Plus plans only*
LIFETIME MAXIMUM PLAN PAYMENT	$2,500,000	$1,000,000
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
DEDUCTIBLES & OUT-OF-POCKET MAXIMUMS Deductible included in the out-of-pocket maximum	**Opt. 1** — Deductible / Out-of-Pocket Maximum **Single:** $1,500 / $5,000 **Family:** $3,000 / $10,000 **Opt. 2** **Single:** $2,700 / $5,000 **Family:** $5,400 / $10,000	**Opt. 1** — Deductible / Out-of-Pocket Maximum **Single:** $2,000 / $7,000 **Family:** $4,000 / $14,000 **Opt. 2** **Single:** $3,200 / $7,000 **Family:** $6,400 / $14,000
INPATIENT SERVICES Medical, Surgical, Emergency Admissions, Hospice Skilled Nursing Facility Physical, Speech, and Occupational Therapy	You pay 20% after deductible	You pay 40% after deductible
PROFESSIONAL SERVICES Office Visits–PCP[3] Office Visits–SCP[3] Immunizations Elective Immunizations	You pay $15 after deductible You pay $25 after deductible Covered 100% You pay 20%	You pay 40% after deductible ($15 min copay) You pay 40% after deductible ($25 min copay) Not covered Not covered
PREVENTIVE CARE (Deductible waived) Office Visits–PCP[3] Office Visits–SCP[3]	You pay $15 You pay $25	Not covered Not covered
OUTPATIENT SERVICES Participating Emergency Room Visit Nonparticipating Emergency Room Visit Intermountain InstaCare Facility/Urgent Care Intermountain KidsCare Facility (See preventive care if services are preventive) Diagnostic Tests, Minor Diagnostic Tests, Major Physical, Speech, and Occupational Therapy	You pay $100 after deductible You pay $200 after deductible You pay $25 after deductible You pay $15 after deductible Covered 100% after deductible You pay 20% after deductible You pay $25 after deductible	See "Participating Benefits" See "Participating Benefits" You pay 40% after deductible Not available You pay 40% after deductible You pay 40% after deductible You pay 40% after deductible ($25 min. copay)
MENTAL HEALTH & CHEMICAL DEPENDENCY Inpatient limited to 10 days/calendar year Outpatient limited to 25 visits/calendar year	You pay 50% after deductible	You pay 50% after deductible
MISCELLANEOUS SERVICES Infertility (limited to $1,500/calendar year; $5,000/lifetime) Maternity and Adoption Chiropractic	You pay 50% after deductible Not covered Not covered	Not covered Not covered Not covered
SUPPLEMENTAL ACCIDENT	Not available	Not available
PRESCRIPTION DRUGS Up to a 30-day supply for covered medications; generic substitution required; same copay/coinsurance applies to 90-day maintenance home delivery supply	Tier 1: You pay $10 after deductible Tier 2: You pay 25% after deductible Tier 3: You pay 50% after deductible	Tier 1: You pay $10 after deductible Tier 2: You pay 25% after deductible Tier 3: You pay 50% after deductible

BENEFIT SUMMARY FOOTNOTES:

1. Precertification for nonparticipating providers is required for all inpatient services, durable medical equipment with purchase price of more than $750, home health nursing services, and pain management/pain clinic services. If you fail to precertify, benefits are reduced to 50 percent and will not be applied to the out-of-pocket maximum.
2. The following services are not covered when provided by a nonparticipating provider: preventive care, immunizations, infertility, allergy tests, and allergy treatments.
3. PCP (Primary Care Provider); SCP (Secondary Care Provider).

HealthSave Benefit Summary – 100% Plans

This table is for comparison purposes only and does not replace the Member Payment Summary. Please refer to the Contract and Member Payment Summary for detailed benefit information.

BENEFITS	PARTICIPATING BENEFITS *HMO & Plus plans*	NONPARTICIPATING BENEFITS[1,2] *Plus plans only*
LIFETIME MAXIMUM PLAN PAYMENT	$2,500,000	$1,000,000
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
DEDUCTIBLE & OUT-OF-POCKET MAXIMUMS Deductible included in the out-of-pocket maximum	Deductible / Out-of-Pocket Maximum **Single:** $5,000 / $5,000 **Family:** $10,000 / $10,000	Deductible / Out-of-Pocket Maximum **Single:** $7,500 / $7,500 **Family:** $15,000 / $15,000
INPATIENT SERVICES Medical, Surgical, Emergency Admissions, Hospice Skilled Nursing Facility Physical, Speech, and Occupational Therapy	Covered 100% after deductible	Covered 100% after deductible
PROFESSIONAL SERVICES		
Office Visits–PCP[3]	Covered 100% after deductible	Covered 100% after deductible
Office Visits–SCP[3]	Covered 100% after deductible	Covered 100% after deductible
Immunizations	Covered 100%	Not covered
Elective Immunizations	Covered 100%	Not covered
PREVENTIVE CARE (Deductible waived)		
Office Visits–PCP[3]	You pay $15	Not covered
Office Visits–SCP[3]	You pay $25	Not covered
OUTPATIENT SERVICES		
Participating Emergency Room Visit	Covered 100% after deductible	See "Participating Benefits"
Nonparticipating Emergency Room Visit	Covered 100% after deductible	See "Participating Benefits"
Intermountain InstaCare Facility/Urgent Care	Covered 100% after deductible	Covered 100% after deductible
Intermountain KidsCare Facility (See preventive care if services are preventive)	Covered 100% after deductible	Not available
Diagnostic Tests, Minor	Covered 100% after deductible	Covered 100% after deductible
Diagnostic Tests, Major	Covered 100% after deductible	Covered 100% after deductible
Physical, Speech, and Occupational Therapy	Covered 100% after deductible	Covered 100% after deductible
MENTAL HEALTH & CHEMICAL DEPENDENCY Inpatient limited to 10 days/calendar year Outpatient limited to 25 visits/calendar year	Covered 100% after deductible	Covered 100% after deductible
MISCELLANEOUS SERVICES		
Infertility (limited to $1,500/calendar year; $5,000/lifetime)	Covered 100% after deductible	Not covered
Maternity and Adoption	Not covered	Not covered
Chiropractic	Not covered	Not covered
SUPPLEMENTAL ACCIDENT	Not available	Not available
PRESCRIPTION DRUGS Up to a 30-day supply for covered medications; generic substitution required; same copay/coinsurance applies to 90-day maintenance home delivery supply	Tier 1: Covered 100% after deductible Tier 2: Covered 100% after deductible Tier 3: Covered 100% after deductible	Tier 1: Covered 100% after deductible Tier 2: Covered 100% after deductible Tier 3: Covered 100% after deductible

BENEFIT SUMMARY FOOTNOTES:

1. Precertification for nonparticipating providers is required for all inpatient services, durable medical equipment with purchase price of more than $750, home health nursing services, and pain management/pain clinic services. If you fail to precertify, benefits are reduced to 50 percent and will not be applied to the out-of-pocket maximum.
2. The following services are not covered when provided by a nonparticipating provider: preventive care, immunizations, infertility, allergy tests, and allergy treatments.
3. PCP (Primary Care Provider); SCP (Secondary Care Provider).