

IHC Small Employer Products 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 for detailed benefit information.

LEGEND: ACD - After Combined Deductible

This benefit summary indicates the amount the employee is responsible to pay for covered services. See footnotes on the following page

BENEFITS	OPTION 1 OPEN PANEL			
	HMO	PLUS		
Access to Participating/ Nonparticipating Providers	Participating Only	Participating	Nonparticipating ^{2,8}	
Lifetime Maximum Plan Payment (per person)	\$2,500,000	\$2,500,000	\$1,000,000	
Maximum Annual Out-of-Network Plan Payment	Not applicable	Not applicable	None	
Pre-Existing Conditions	Same benefit applies to all plans			
Deductibles & Out-of-Pocket (OOP) Maximums (Calendar year)	Not covered for first 12 months ¹ (18 months for late enrollees)			
Deductible is included in the Out-of-Pocket Maximum.		<u>Option 1</u>	<u>Option 2</u>	<u>Option 3</u>
Medical Deductible (Individual/Family)		\$250/\$750	\$500/\$1,000	\$1,000/\$2,000
Medical OOP (Individual/Family)		\$2,000/\$4,000	\$3,000/\$6,000	\$3,000/\$6,000
Rx Deductible (Individual)		\$75	\$125	\$350
Rx OOP (Individual)		\$4,000	\$4,000	\$4,000
Waiver of Deductible for Office Visits is available.				
Rx Deductible Waiver option is also available.				
Coinsurance/Copay Combinations		<u>Option 1</u>	<u>Option 2</u>	<u>Option 3</u>
Coinsurance applies to: Inpatient services, maternity, ⁶ adoption, ^{6,7} outpatient services, physician fees, ambulance, chemotherapy, radiation, dialysis, home health, durable medical equipment, injectable drugs, allergy treatment, ³ major diagnostic tests, miscellaneous medical supplies.				
Limit for inpatient skilled nursing facility is 60 days per calendar year. Limit for inpatient rehab therapy is 40 days per calendar year.				
Office Visits				
Emergency Room Visit				
Prescription Drugs				
Generic substitution required				
IHC InstaCare SM /Urgent Care				
IHC KidsCare SM				
Immunizations				
Minor Diagnostic Tests				
Infertility				
Outpatient Rehab Therapy – physical, speech, occupational. Visit limit for outpatient rehab therapy is 20 per calendar year. Limit applies separately for each therapy type.				
Mental Health & Chemical Dependency				
Catastrophic mental health coverage is available ¹⁰				
Chiropractic				
Supplemental Accident				

See footnotes on the following page

AMD - After Medical Deductible ARxD - After Rx Deductible

OPTION 2 HEALTH CHOICE PREMIER

OPTION 3 HEALTHSAVE

Health Choice PremierSM

HealthSaveSM

Participating

Nonparticipating²

Participating Only

\$2,500,000

\$2,500,000

Not applicable

\$500,000

Not applicable

Option 1 Option 2 Option 3 Option 4

	(Individual/Family)	(Individual/Family)	(Individual/Family)	(Individual/Family)
Medical Deductible				
Participating	\$250/\$750	\$500/\$1,000	\$1,000/\$2,000	\$2,000/\$4,000
Nonparticipating	\$500/\$1,000	\$750/\$1,500	\$1,500/\$3,000	\$3,000/\$6,000
Medical OOP				
Participating	\$2,000/\$4,000	\$3,000/\$6,000	\$3,000/\$6,000	\$4,000/\$6,000
Nonparticipating	\$3,000/\$6,000	\$4,500/\$9,000	\$4,500/\$9,000	\$6,000/\$9,000
Rx Deductible	(Individual) \$75	(Individual) \$125	(Individual) \$350	(Individual) \$1,000
Rx OOP	(Individual) \$4,000	(Individual) \$4,000	(Individual) \$4,000	(Individual) \$4,000

Option 1 Option 2 Option 3

	(Single/Family)	(Single/Family)	(Single/Family)
Deductible	\$1,500/\$3,000	\$2,700/\$5,400	\$5,000/\$10,000
OOP Max	\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000

Participating Coinsurance
20% (AMD)

Nonparticipating Coinsurance
40% (AMD)

Participating Office Visits
PCP: \$15 (AMD)³
SCP: \$25 (AMD)³

Nonparticipating Office Visits
PCP: \$15 + 20% (AMD)
SCP: \$25 + 20% (AMD)

Participating ER
\$100 (AMD)

Nonparticipating ER
\$100 + 20% (AMD)

Tier I: \$10 (ARxD)⁴
Tier II: 25% (ARxD)⁴
Tier III: 50% (ARxD)⁴

Tier I: \$10 (ARxD)⁴
Tier II: 25% (ARxD)⁴
Tier III: 50% (ARxD)⁴

\$25 (AMD)³

\$25 + 20% (AMD)

\$15 (AMD)³

Not applicable

Covered 100%

20% (AMD)

Covered 100% (AMD)³

20% (AMD)

50% (AMD)⁵

50% (AMD)⁵

\$25 (AMD)

\$25 + 20% (AMD)

50% (AMD)⁵

50% (AMD)⁵

Inpatient day limit: 10 per calendar year
Outpatient visit limit: 15 per calendar year

Inpatient day limit: 10 per calendar year
Outpatient visit limit: 15 per calendar year

\$25 (AMD)

\$25 + 20% (AMD)

Available

Coinsurance	20%(ACD)	20% (ACD)	Covered 100% (ACD)
Office Visits			
PCP	\$15 (ACD) ⁹	\$15 (ACD) ⁹	\$15 (ACD) ⁹
SCP	\$25 (ACD) ⁹	\$25 (ACD) ⁹	\$25 (ACD) ⁹
ER Visit			
Par	\$100 (ACD)	\$100 (ACD)	Covered 100% (ACD)
Nonpar	\$200 (ACD)	\$200 (ACD)	Covered 100% (ACD)

Tier I: \$10 (ACD)
Tier II: 25% (ACD)
Tier III: 50% (ACD)

\$25 (ACD)

\$15 (ACD)⁹

Covered 100%

Covered 100% (ACD)⁹

50% (ACD)

\$25 (ACD)

50% (ACD)

Inpatient day limit: 10 per calendar year
Outpatient visit limit: 15 per calendar year

Not Covered

Not available

Benefit Summary Footnotes

1. **Pre-existing conditions** - Pre-existing limitations are waived (entirely or partially) for qualifying pre-existing credit.
2. **Precertification** - Precertification is required for the following: all inpatient services; maternity stays longer than two days for a normal delivery or longer than four days for a cesarean; DME 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.
3. **Waiver of Deductible for Office Visits** - The deductible will not apply to participating office visits (including minor diagnostics tests), IHC InstaCares, or IHC KidsCares if the waiver of Deductible for Office Visits is selected.
4. **Rx Deductible Waiver** - The Rx deductible will not apply if the Rx Deductible Waiver is selected (only available if the Waiver of Deductible for Office Visits option is also selected).
5. **Not applied to out-of-pocket maximum**
6. **Maternity** - For groups with 14 or fewer employees, a lower-cost maternity and adoption coverage option is available. **For Open Panel and Health Choice Premier**, the lower maternity option applies a \$5,000 per calendar year maternity deductible. After the deductible is met, maternity services for participating providers are covered at 100 percent. The \$5,000 maternity deductible also applies to adoption services and may exhaust the benefit prior to any plan payment. With this option, maternity and adoption do not apply to the out-of-pocket maximum. **For HealthSave**, the lower maternity option excludes maternity and adoption services from coverage.
7. **Adoption** - IHC Health Plans provides an adoption indemnity benefit as outlined by the state of Utah. Participating deductible and coinsurance applies.
8. **Services not covered from nonparticipating providers** - The following services are not covered when you go to a nonparticipating provider: preventive care, immunizations, infertility, allergy tests, and allergy treatments.
9. **Preventive Care Deductible Waiver** - Benefits for preventive care services are paid before the deductible is met.
10. **Catastrophic Mental Health** - Catastrophic mental health coverage is available for employers wanting to enhance their coverage.
11. **Supplemental Accident** - For those employers that would like to enhance their coverage, a supplemental accident option is available. With this option, the first \$1,000 of accident-related services are covered at 100 percent per person/calendar year (services must be received within one year of accident).