

Benefits Manager, Inc

Enrollment Instructions for IHC Health Plans

Here is a checklist of a few things that are commonly overlooked and are mandatory for processing your application.

- Complete all questions and sections of the application by tabbing to each entry and filling out the requested information.

Don't forget to -

- Enter your required effective date. Remember you must submit to our office by the 25th of the month in order to qualify for your policy to be effective on the 1st of the following month.
- Select your preferred billing method.
- Print two copies of the application one for yourself and one to send to Benefits Manager.
- Sign and date the application.
- If you have requested that your monthly premium be deducted automatically from your checking account, you must sign and date the authorization form, attach a voided check to it, and include a check or money order payable to IHC Health Plans for the first month's premium.

Or

- If you have chosen 6-month prepayment include a check or money order payable to IHC Health Plans for the first six months' premium with the submission of the application.
- Mail completed, originally signed application and check if applicable to:
Benefits Manager, Inc
Attn: New Enrollment
1235 W. Stone Creek Ln.
Layton, UT 84041

As an example of one of many of our free services to our clients, Benefits Manager, Inc will review your application for completeness and accuracy before we submit it to IHC Health Plans for approval. This will greatly reduce the approval time because IHC Health Plans does not process unclear or incomplete applications until the missing information has been gathered.

After your application has been reviewed by Benefits Manager it will be submitted to *IHC Health Plans* for processing. If errors are found, please make any necessary changes and re-mail the corrected application to Benefits Manager for processing.

Please contact us if you have any questions regarding the application or enrollment process. You may reach us at (888)310-9623 or e-mail us at mikeoliphant@benefitsmanager.net.

Thank you for giving us this opportunity to serve you. We want to earn the right to have you as one of our **Clients for Life**.

The Benefits Manager Team

Please use ink and print legibly

I. APPLICANT INFORMATION (Must be oldest family member)

| | | |
|--------------------------------|--------------------------|--|
| Last Name | First Name | Initial |
| Street Address | Unit # | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced |
| City | State | ZIP |
| Mailing Address (If different) | | |
| Street Address | | |
| City | State | ZIP |
| Your Occupation | Your Spouse's Occupation | |
| E-Mail Address | Home Ph # () | Work Ph # () |

Please check one of the following boxes: New Application Dependent Addition Re-apply
 Payment Option Pre-Authorized Banking Withdrawal Electronic Billing and Payment (See Payment Selection Form)

II. APPLICANT AND DEPENDENT INFORMATION

IN THE SECTION BELOW, LIST YOURSELF AND ELIGIBLE FAMILY MEMBERS TO BE INCLUDED UNDER MEDICAL COVERAGE.

| RELATIONSHIP | NAME (FIRST, MIDDLE INITIAL, LAST) | SOCIAL SECURITY # (For Internal Use Only) | SEX | BIRTH DATE (MM/DD/YY) | AGE |
|---------------------|---------------------------------------|--|-----|--------------------------|-----|
| Self | | | | | |
| Spouse ¹ | | | | | |
| Child ² | | | | | |
| Child ² | | | | | |
| Child ² | | | | | |
| Child ² | | | | | |

- If you are **adding your spouse**, he or she may only be deleted from your coverage under the following circumstances:
 - When your spouse agrees to be deleted from coverage by signing a Personal Plan's Change Form; or
 - When proof of a legal divorce or annulment is given (first and last page of the divorce decree and any page in between specifying coverage responsibilities for dependent children if you have elected family coverage).
- To be eligible for coverage, **children must be under the age of 26, unmarried, and dependent upon you** for 50 percent of their financial support. (Financial dependency is not required for court ordered dependent coverage.) Any dependent not listed will not be considered for coverage.

III. DUAL COVERAGE/COORDINATION OF BENEFITS INFORMATION

For Dual Coverage/Coordination of Benefit purposes, indicate each individual who will also be covered by other medical insurance **while coverage with IHC is in force**. Please do not complete this section if other coverage will be terminated once the IHC health plan is in force.

| RELATIONSHIP | NAME OF INDIVIDUALS COVERED BY OTHER INSURANCE | CARRIER NAME | CARRIER PH # | POLICY NUMBER | EFFECTIVE DATE |
|--------------|---|--------------|--------------|---------------|----------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

IHC HEALTH PLANS' USE ONLY

| | | | |
|----------------|------|--|--------------------|
| Class # | Plan | Agent/Broker | Agent/Broker # |
| Effective Date | | Rate Adjustment Percent | Monthly Payment \$ |
| PEC Start Date | | PEC Credit | |
| HPI Notes | | HSA <input type="checkbox"/> Yes <input type="checkbox"/> No | |

IF YOU NEED ADDITIONAL SPACE, PLEASE USE ANOTHER APPLICATION FORM.

IV. PLAN INFORMATION

SELECT ONE FROM EACH OF THE FOLLOWING: Network, Plan Option, and associated Benefit Section



NETWORK

IHC MedSM

SelectMedSM

IHC CareSM

Select one network

PLAN OPTION

HMO Plans

HealthSaveSM

Select one plan option and complete associated Benefit Section below

IF you are selecting an HMO Plan, complete the HMO Benefit Section.

IF you are selecting the HealthSave option, complete the HealthSave Benefit Section.

HMO Benefit Section

Only for HMO

BENEFIT AND DEDUCTIBLE Select benefit level (Base, Mid, or High) and deductible

Base-Level Plan

Deductible applies to all services first

- \$250 Medical Ded (\$100 Rx Ded)
- \$500 Medical Ded (\$200 Rx Ded)
- \$1,000 Medical Ded (\$400 Rx Ded)
- \$2,500 Medical Ded (\$1,000 Rx Ded)

Mid-Level Plan

No deductible for office visits, with deductible for Rx

- \$250 Medical Ded (\$100 Rx Ded)
- \$500 Medical Ded (\$200 Rx Ded)

High-Level Plan

No deductible for office visits, no deductible for Rx

- \$250 Medical Ded
- \$500 Medical Ded
- \$1,000 Medical Ded

COINSURANCE/COPAY Select one coinsurance and copay amount

- 70/30-\$25/35
- 80/20-\$15/25

HealthSave Benefit Section

Only for HealthSave

DEDUCTIBLE Select one deductible either under Single or Family

Deductible applies to all services except preventive care

Single (One person)

- \$1,500 Deductible (You pay 20% coinsurance after deductible)
- \$2,700 Deductible (You pay 20% coinsurance after deductible)
- \$5,000 Deductible (Covered 100% after deductible)

Family (Two or more)

- \$3,000 Deductible (You pay 20% coinsurance after deductible)
- \$5,400 Deductible (You pay 20% coinsurance after deductible)
- \$10,000 Deductible (Covered 100% after deductible)

Are you electing to use IHC Health Plans' preferred HSA vendor? (Selected HSA Vendor)

- Yes No

Note: An administrative fee of \$3.50 per month is included in your premium amount, regardless of whether you choose to use the preferred HSA vendor.

You may choose to use this option with a Health Savings Account (HSA). IHC Health Plans has made a concerted effort to design the coverage in compliance with the requirements for a High Deductible Health Plan (HDHP) under federal law (Section 223 of the Internal Revenue Code).

However, IHC Health Plans makes no representations or warranties about the legal adequacy of this coverage as an HSA compatible plan. IHC Health Plans is not responsible for any issues relating to your use of the coverage in conjunction with an HSA including, without limitation, your compliance with the requirements of the Internal Revenue Code.

Authorization to Disclose Health Information to IHC Health Plans for Pre-Enrollment Underwriting Purposes

Notice: By signing this form, you give IHC Health Plans the right to gather medical information about you and your dependents for whom you have legal authority to sign (e.g., a minor child). IHC Health Plans typically gathers both paper and electronic records. This information helps IHC Health Plans make an educated decision about insuring you and your dependents.

I. Identifying Information for the Applicant and Dependents

| | |
|-----------------|---|
| Applicant | Date of Birth |
| Spouse | Date of Birth |
| Child | Date of Birth |
| Child | Date of Birth |
| Child | Date of Birth |
| Child | Date of Birth |
| Child | Date of Birth |
| Child | Date of Birth |
| Current Address | City State Zip |
| Phone Number | |

II. Authorization

| |
|--|
| <p>I authorize any health plan and any health care provider (including any pharmacy) to disclose medical information about me to IHC Health Plans for purposes of determining my eligibility for health insurance coverage as requested in the application dated _____ ("My Application"). The medical information I authorize to be disclosed includes any medical information related to my insurability, except for any genetic test results about me or a blood relative of mine.*</p> |
|--|

*Utah law prohibits insurers from using genetic test results for underwriting purposes.

III. Information for Applicant and Dependents

| |
|--|
| <p>I understand the following information:</p> <ol style="list-style-type: none"> 1. I may refuse to sign this Authorization, or I may revoke it if I have not been enrolled in IHC Health Plans by sending my written request to the address above; however, if I do so IHC Health Plans may refuse to enroll me; 2. A health care provider may not condition my treatment on my signing this Authorization; 3. Another health plan may not condition payment, enrollment, or eligibility for benefits on my signing this Authorization; 4. I understand that the information that IHC Health Plans receives because of this Authorization may be redisclosed and no longer protected by federal or state regulation. Items 5 and 6 of this section limit the potential for redisclosure of my information. 5. If IHC Health Plans does not enroll me, it may not use or disclose the information it receives because of this Authorization for any purpose other than underwriting, except as may be required by law (if IHC Health Plans denies insurance coverage because of an individual's health condition, Utah law requires IHC Health Plans to tell the applicant specifically what this health condition is); 6. If IHC Health Plans does enroll me, it will only use information disclosed to it under this Authorization for purposes described in its notice of privacy practices; 7. Unless revoked, this Authorization will remain in effect until the earlier of: <ol style="list-style-type: none"> a. The date that IHC Health Plans has rejected My Application for insurance; or b. 60 calendar days from the date of my application. |
|--|

IV. Signatures

| | | |
|-----------|---|------|
| Applicant | If signed by representative, legal authority [#] | Date |
| Spouse | If signed by representative, legal authority [#] | Date |
| Child | If signed by representative, legal authority [#] | Date |
| Child | If signed by representative, legal authority [#] | Date |
| Child | If signed by representative, legal authority [#] | Date |
| Child | If signed by representative, legal authority [#] | Date |
| Child | If signed by representative, legal authority [#] | Date |

[#]A representative must have legal authority to sign (e.g., a parent/guardian for a minor child). Generally, a spouse and children over 18 years of age must sign for themselves.

X. AUTHORIZATION AND ACKNOWLEDGMENT

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage with IHC Health Plans, Inc. When incorporated with the Contract, this Application and the Member Payment Summary become part of the Contract. Once fully signed and executed, Plan and I agree to terms set forth in the Contract. In connection with both this Application and any Plan coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. Further, in dealing with IHC Health Plans, I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable underwriting criteria. I also understand that no coverage will be in force until each person listed above is approved by IHC Health Plans, that no benefits will be provided for any services which begin before the coverage is effective, and that except as expressly provided in the Contract, benefits will not extend beyond the termination of either my coverage or the Contract.

CONSENT AT ENROLLMENT. I understand that no agent or Plan representative is allowed to permit me to answer any questions inaccurately, untruthful, or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to the Plan changes in the eligibility of any applicants who become members.

I understand that the data obtained by the use of this authorization will only be used to determine eligibility for coverage and for future benefit administration. I understand that my choice of health care providers whose services will be covered may be restricted by the Contract, and I agree that any services which are obtained without or contrary to required preauthorization/precertification requirements in the Contract may be denied coverage. I understand the coverage for which I am applying may limit or exclude certain conditions and may exclude conditions for which a family member (including myself) has received any medical diagnosis or treatment or taken any medication or where symptoms were or should have been evident prior to his or her coverage effective date, according to the pre-existing conditions limitation provisions of the Contract. I understand that this Application will become part of the Contract.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE. According to information you have furnished, you may intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by IHC Health Plans, Inc. Your new policy provides ten days within which you may decide without cost whether you desire to keep the plan. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new plan.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new plan. This could result in a denial or delay of a claim for benefits under the new plan, whereas a similar claim might have been payable under your present policy or plan.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical or health history.
4. Failure to include all material medical information on an application may provide a basis for the Plan to deny any future claims and to refund your premium as though your plan had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

I hereby declare that to the best of my knowledge and belief, the information given on this Application, including the health information on pages two and three of this Application, is correctly recorded, true, and complete. I understand that material omissions or intentional misrepresentations regarding information provided on this Application could cause an otherwise covered service to be denied and/or could void any coverage issued. If I subsequently become aware of information different from that provided in this Application, I agree to provide that additional information promptly to IHC Health Plans.

XI. SIGNATURE OF APPLICANT AND SPOUSE

Signature _____ Date Signed _____
Spouse's Signature _____ Date Signed _____
(Required if applying for coverage)

XII. AGENT/BROKER AGREEMENT (IF APPLICABLE)

I understand and agree that in acting as the agent/broker for this applicant:

1. The application was completed by the applicant;
2. I am in possession of a valid license issued by the state of Utah that authorizes me to sell and service health insurance contracts;
3. I have no authority to: **a)** make, alter, interpret, or discharge an application or contract in the name of IHC Health Plans, Inc., or **b)** waive any of the terms of conditions of the Contract.
4. I have no authority to assign effective dates or to affect membership changes.
5. Cancellation of this Health Care Agreement by either the subscriber or IHC Health Plans, Inc. will terminate this Agency Agreement.

Date application received at
IHC Health Plans, Inc.

Agent/
Broker Name _____ Agency _____ PH# _____
Agent Signature _____ Date Signed _____

Requested Effective Date _____

Coverage is not in force until your application is approved and an effective date is determined by IHC Health Plans, Inc.

IF YOU NEED ADDITIONAL SPACE, PLEASE USE ANOTHER APPLICATION FORM.

Applicant's Name _____ Applicant's Social Security # OR Subscriber ID (for internal use only) _____

A. PAYMENT SELECTION

Please select one of the two available methods of payment for your monthly premium. **Your employer cannot** pay any portion of your premium, either directly or through reimbursement. Submit only personal account information.

Pre-Authorized Banking Withdrawal
(Complete Section B)

Electronic Billing and Payment
(Complete Section C. You must include a check for the first month's premium)

B. PRE-AUTHORIZED BANKING WITHDRAWAL

If you select this method of payment for your monthly premium, your payment will automatically be deducted from your checking/savings account each month. Please complete the information below.

I (we) authorize IHC Health Plans, Inc. to initiate debit entries to my (our): **Checking Account** **Savings Account**

Account Holder's Name

Account Number

Financial Institution

Routing and Transit Number

I (we) understand that debit entries will be submitted to my (our) account on or about the 10th of each month, regardless of the policy effective date. I (we) understand that a **\$25.00 service charge** will be assessed if the premium amount cannot be deducted from my (our) account for any reason.

Account Holder's Signature

Date

Pre-Authorized Banking Withdrawal

Attach a Voided Check Here

*Do not use a checking deposit slip for checking withdrawal.
Checking deposit slips do not always contain the necessary routing and transit information.*

C. ELECTRONIC BILLING AND PAYMENT

If you have selected the Electronic Billing and Payment option, complete and sign the agreement below. You will receive your monthly statement by e-mail. This e-mail will link you to an Internet site where you can make your monthly payment by electronic check or by credit card.

This method of payment requires that you submit the first month's premium, using a check or credit card with your application. Premium payments are due on the first day of each month.

Applicant's Signature

Applicant's Phone #

Applicant's E-mail Address

Applicant's Date of Birth

HMO 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.*

| BENEFITS | HMO – 80/20 Coinsurance | HMO – 70/30 Coinsurance | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--------------------------|--------------------|-----------------------|---------------|--------------------------|-------------|-----------------|-------|---------|---------------|-----------------|-------|---------|-----------------|-----------------|-------|---------|-----------------|-----------------|---------|---------|
| Lifetime Maximum Plan Payment | \$2,500,000 | \$2,500,000 | | | | | | | | | | | | | | | | | | | | | |
| Pre-existing Conditions | Not covered for first 12 months ¹ | Not covered for first 12 months ¹ | | | | | | | | | | | | | | | | | | | | | |
| Deductibles & Out-of-Pocket Maximums (Individual/Family) Deductible is included in the out-of-pocket maximum. <i>Three benefit levels are available. You can enhance your coverage by selecting the mid or high level. Levels are described the following ways:</i> Base-Level – Medical and Rx deductibles apply to all services first. Mid-Level – The Medical deductible is waived for office, IHC KidsCare, and IHC InstaCare visits. Rx deductible applies. High-Level – The Medical deductible is waived for office, IHC KidsCare, and IHC InstaCare visits. No Rx deductible applies. | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-decoration: underline;">Medical Deductible</th> <th style="text-decoration: underline;">Medical Out-of-Pocket</th> <th style="text-decoration: underline;">Rx Deductible</th> <th style="text-decoration: underline;">Rx Out-of-Pocket Maximum</th> </tr> </thead> <tbody> <tr> <td>\$250/\$750</td> <td>\$2,500/\$5,000</td> <td>\$100</td> <td>\$4,000</td> </tr> <tr> <td>\$500/\$1,500</td> <td>\$3,000/\$6,000</td> <td>\$200</td> <td>\$4,000</td> </tr> <tr> <td>\$1,000/\$2,500</td> <td>\$3,500/\$7,000</td> <td>\$400</td> <td>\$4,000</td> </tr> <tr> <td>\$2,500/\$5,000</td> <td>\$4,000/\$8,000</td> <td>\$1,000</td> <td>\$4,000</td> </tr> </tbody> </table> | | | Medical Deductible | Medical Out-of-Pocket | Rx Deductible | Rx Out-of-Pocket Maximum | \$250/\$750 | \$2,500/\$5,000 | \$100 | \$4,000 | \$500/\$1,500 | \$3,000/\$6,000 | \$200 | \$4,000 | \$1,000/\$2,500 | \$3,500/\$7,000 | \$400 | \$4,000 | \$2,500/\$5,000 | \$4,000/\$8,000 | \$1,000 | \$4,000 |
| Medical Deductible | Medical Out-of-Pocket | Rx Deductible | Rx Out-of-Pocket Maximum | | | | | | | | | | | | | | | | | | | | |
| \$250/\$750 | \$2,500/\$5,000 | \$100 | \$4,000 | | | | | | | | | | | | | | | | | | | | |
| \$500/\$1,500 | \$3,000/\$6,000 | \$200 | \$4,000 | | | | | | | | | | | | | | | | | | | | |
| \$1,000/\$2,500 | \$3,500/\$7,000 | \$400 | \$4,000 | | | | | | | | | | | | | | | | | | | | |
| \$2,500/\$5,000 | \$4,000/\$8,000 | \$1,000 | \$4,000 | | | | | | | | | | | | | | | | | | | | |
| Office Visit Copay Primary Care Provider (PCP) Secondary Care Provider (SCP) | PCP: You pay \$15 after deductible ² SCP: You pay \$25 after deductible ² | PCP: You pay \$25 after deductible ² SCP: You pay \$35 after deductible ² | | | | | | | | | | | | | | | | | | | | | |
| Emergency Room Visits Participating (Par) Nonparticipating (Nonpar) | Par: You pay \$100 after deductible Nonpar: You pay \$200 after deductible | Par: You pay \$125 after deductible Nonpar: You pay \$250 after deductible | | | | | | | | | | | | | | | | | | | | | |
| Prescription Drugs <i>Up to a 30-day supply for covered medications; generic substitution required; same copay/coinsurance applies to 90-day maintenance home delivery supply.</i> | Tier I: You pay \$10 after Rx deductible ³ Tier II: You pay 25% after Rx deductible ³ Tier III: You pay 50% after Rx deductible ³ | Tier I: You pay \$10 after Rx deductible ³ Tier II: You pay 25% after Rx deductible ³ Tier III: You pay 50% after Rx deductible ³ | | | | | | | | | | | | | | | | | | | | | |
| Coinsurance Includes: Inpatient services, outpatient services, physicians fees, ambulance, chemotherapy, radiation, dialysis, home health, durable medical equipment, injectable drugs, allergy treatment, ² major diagnostic tests, miscellaneous medical supplies. <i>Limit for inpatient skilled nursing facility is 60 days per calendar year. Limit for inpatient rehab therapy is 40 days per calendar year.</i> | You pay 20% after deductible | You pay 30% after deductible | | | | | | | | | | | | | | | | | | | | | |
| IHC InstaCare/Urgent Care Facility | You pay \$25 after deductible ² | You pay \$35 after deductible ² | | | | | | | | | | | | | | | | | | | | | |

HMO BENEFIT SUMMARY

| BENEFITS | HMO – 80/20 Coinsurance | HMO – 70/30 Coinsurance |
|---|---|---|
| IHC KidsCare Facility | You pay \$15 after deductible ² | You pay \$25 after deductible ² |
| Immunizations | Covered at 100% | Covered at 100% |
| Minor Diagnostic Tests | Covered 100% after deductible ² | Covered 100% after deductible ² |
| Infertility <i>Not applied to the out-of-pocket maximum.</i> | You pay 50% after deductible Maximum plan payment is \$1,500 per calendar year; \$5,000 lifetime | You pay 50% after deductible Maximum plan payment is \$1,500 per calendar year; \$5,000 lifetime |
| Outpatient Rehab Therapy <i>Visit limit for outpatient rehab therapy is 20 per calendar year.</i> | You pay \$25 after deductible | You pay \$35 after deductible |
| Mental Health & Chemical Dependency <i>Not applied to the out-of-pocket maximum.</i> | You pay 50% after deductible Day limit for inpatient is 10 per calendar year Visit limit for outpatient is 15 per calendar year | You pay 50% after deductible Day limit for inpatient is 10 per calendar year Visit limit for outpatient is 15 per calendar year |
| Maternity & Adoption <i>Not applied to the out-of-pocket maximum.</i> | Covered 100% after \$5,000 calendar year maternity deductible IHC Health Plans provides an adoption indemnity benefit as outlined by the state of Utah. Maternity deductible applies and may exhaust the benefit prior to any plan payment | Covered 100% after \$5,000 calendar year maternity deductible IHC Health Plans provides an adoption indemnity benefit as outlined by the state of Utah. Maternity deductible applies and may exhaust the benefit prior to any plan payment |
| Chiropractic | Not covered | Not covered |
| Supplemental Accident <i>Per person/calendar year</i> | 1st \$1,000 covered 100% | 1st \$1,000 covered 100% |

FOOTNOTES

1. Waived (entirely or partially) for qualifying pre-existing condition credit
2. Deductible will not apply when you have selected the mid- or high-level plans
3. The Rx deductible will not apply when you have selected the high-level plan

80%/20% COINSURANCE OPTION HMO MID-LEVEL PREMIUM RATES

No deductible for office visits. With deductible for Rx.



IHC MEDSM
A Product of IHC Health Plans

| Deductibles Age | \$250 Medical \$100 Rx | | | \$500 Medical \$200 Rx | | |
|--------------------|---------------------------|---------|--------|---------------------------|---------|--------|
| | Single | 2-Party | Family | Single | 2-Party | Family |
| 0 - 19 | 86 | 154 | 226 | 75 | 135 | 198 |
| 20 - 24 | 91 | 174 | 243 | 80 | 152 | 212 |
| 25 - 29 | 105 | 198 | 301 | 92 | 173 | 264 |
| 30 - 34 | 120 | 227 | 366 | 105 | 198 | 321 |
| 35 - 39 | 129 | 231 | 419 | 113 | 202 | 367 |
| 40 - 44 | 148 | 271 | 489 | 130 | 238 | 428 |
| 45 - 49 | 172 | 323 | 553 | 151 | 283 | 484 |
| 50 - 54 | 198 | 383 | 584 | 173 | 336 | 511 |
| 55 - 59 | 236 | 471 | 638 | 206 | 412 | 558 |
| 60 - 64 | 287 | 581 | 744 | 251 | 509 | 651 |



SELECTMEDSM
A Product of IHC Health Plans

| Deductibles Age | \$250 Medical \$100 Rx | | | \$500 Medical \$200 Rx | | |
|--------------------|---------------------------|---------|--------|---------------------------|---------|--------|
| | Single | 2-Party | Family | Single | 2-Party | Family |
| 0 - 19 | 92 | 165 | 242 | 82 | 147 | 215 |
| 20 - 24 | 98 | 187 | 260 | 87 | 166 | 232 |
| 25 - 29 | 113 | 213 | 323 | 100 | 189 | 288 |
| 30 - 34 | 129 | 243 | 393 | 114 | 216 | 350 |
| 35 - 39 | 139 | 248 | 450 | 124 | 220 | 400 |
| 40 - 44 | 159 | 291 | 525 | 142 | 259 | 467 |
| 45 - 49 | 185 | 347 | 593 | 164 | 308 | 528 |
| 50 - 54 | 212 | 412 | 627 | 189 | 366 | 558 |
| 55 - 59 | 253 | 505 | 685 | 225 | 449 | 609 |
| 60 - 64 | 308 | 624 | 799 | 274 | 555 | 710 |



IHC CARESM
A Product of IHC Health Plans

| Deductibles Age | \$250 Medical \$100 Rx | | | \$500 Medical \$200 Rx | | |
|--------------------|---------------------------|---------|--------|---------------------------|---------|--------|
| | Single | 2-Party | Family | Single | 2-Party | Family |
| 0-19 | 104 | 185 | 272 | 90 | 162 | 237 |
| 20 - 24 | 110 | 210 | 292 | 96 | 183 | 255 |
| 25 - 29 | 126 | 239 | 363 | 110 | 209 | 317 |
| 30 - 34 | 144 | 273 | 441 | 126 | 238 | 385 |
| 35 - 39 | 156 | 278 | 505 | 136 | 243 | 441 |
| 40 - 44 | 179 | 327 | 590 | 156 | 286 | 515 |
| 45 - 49 | 207 | 389 | 666 | 181 | 340 | 582 |
| 50 - 54 | 238 | 462 | 704 | 208 | 403 | 615 |
| 55 - 59 | 284 | 567 | 769 | 248 | 495 | 671 |
| 60 - 64 | 346 | 701 | 896 | 302 | 612 | 783 |

80%/20% COINSURANCE OPTION
HMO HIGH-LEVEL PREMIUM RATES

No deductible for office visits. No deductible for Rx.



| Deductible | \$250 Medical | | | \$500 Medical | | | \$1,000 Medical | | |
|------------|---------------|---------|--------|---------------|---------|--------|-----------------|---------|--------|
| | Single | 2-Party | Family | Single | 2-Party | Family | Single | 2-Party | Family |
| Age | | | | | | | | | |
| 0 - 19 | 96 | 172 | 252 | 84 | 151 | 221 | 78 | 140 | 206 |
| 20 - 24 | 102 | 195 | 271 | 89 | 171 | 238 | 83 | 159 | 221 |
| 25 - 29 | 117 | 221 | 337 | 103 | 194 | 295 | 96 | 181 | 275 |
| 30 - 34 | 134 | 253 | 409 | 117 | 222 | 359 | 109 | 207 | 334 |
| 35 - 39 | 145 | 258 | 468 | 127 | 226 | 410 | 118 | 210 | 382 |
| 40 - 44 | 166 | 303 | 547 | 145 | 266 | 479 | 135 | 248 | 446 |
| 45 - 49 | 192 | 361 | 618 | 169 | 316 | 541 | 157 | 295 | 504 |
| 50 - 54 | 221 | 428 | 653 | 194 | 375 | 572 | 180 | 350 | 533 |
| 55 - 59 | 264 | 526 | 713 | 231 | 461 | 625 | 215 | 429 | 582 |
| 60 - 64 | 321 | 650 | 831 | 281 | 569 | 728 | 262 | 530 | 678 |



| Deductible | \$250 Medical | | | \$500 Medical | | | \$1,000 Medical | | |
|------------|---------------|---------|--------|---------------|---------|--------|-----------------|---------|--------|
| | Single | 2-Party | Family | Single | 2-Party | Family | Single | 2-Party | Family |
| Age | | | | | | | | | |
| 0 - 19 | 103 | 185 | 271 | 92 | 164 | 241 | 84 | 150 | 220 |
| 20 - 24 | 109 | 209 | 291 | 97 | 186 | 259 | 89 | 170 | 237 |
| 25 - 29 | 126 | 238 | 361 | 112 | 212 | 322 | 102 | 193 | 294 |
| 30 - 34 | 144 | 272 | 439 | 128 | 242 | 391 | 117 | 221 | 357 |
| 35 - 39 | 155 | 277 | 502 | 138 | 246 | 447 | 126 | 225 | 408 |
| 40 - 44 | 178 | 326 | 587 | 159 | 290 | 523 | 145 | 265 | 477 |
| 45 - 49 | 206 | 387 | 663 | 184 | 345 | 590 | 168 | 315 | 539 |
| 50 - 54 | 237 | 460 | 701 | 211 | 409 | 624 | 193 | 374 | 570 |
| 55 - 59 | 283 | 564 | 765 | 252 | 502 | 681 | 230 | 459 | 622 |
| 60 - 64 | 344 | 697 | 892 | 307 | 621 | 794 | 280 | 567 | 725 |



| Deductible | \$250 Medical | | | \$500 Medical | | | \$1,000 Medical | | |
|------------|---------------|---------|--------|---------------|---------|--------|-----------------|---------|--------|
| | Single | 2-Party | Family | Single | 2-Party | Family | Single | 2-Party | Family |
| Age | | | | | | | | | |
| 0 - 19 | 116 | 207 | 304 | 101 | 181 | 266 | 93 | 167 | 245 |
| 20 - 24 | 122 | 235 | 327 | 107 | 205 | 285 | 99 | 189 | 263 |
| 25 - 29 | 141 | 267 | 406 | 123 | 233 | 355 | 114 | 215 | 327 |
| 30 - 34 | 161 | 305 | 493 | 141 | 267 | 431 | 130 | 246 | 397 |
| 35 - 39 | 174 | 311 | 564 | 152 | 271 | 493 | 140 | 250 | 454 |
| 40 - 44 | 200 | 366 | 659 | 175 | 319 | 576 | 161 | 295 | 531 |
| 45 - 49 | 232 | 435 | 744 | 203 | 380 | 650 | 187 | 350 | 600 |
| 50 - 54 | 266 | 516 | 787 | 233 | 451 | 687 | 215 | 416 | 634 |
| 55 - 59 | 318 | 634 | 859 | 278 | 554 | 751 | 256 | 511 | 692 |
| 60 - 64 | 387 | 783 | 1,002 | 338 | 684 | 875 | 312 | 631 | 807 |

70%/30% COINSURANCE OPTION
HMO BASE-LEVEL PREMIUM RATES

Deductible applies to all services first.



| Deductibles | \$250 Medical | | | \$500 Medical | | | \$1,000 Medical | | | \$2,500 Medical | | |
|-------------|---------------|---------|--------|---------------|---------|--------|-----------------|---------|--------|-----------------|---------|--------|
| | \$100 Rx | | | \$200 Rx | | | \$400 Rx | | | \$1,000 Rx | | |
| Age | Single | 2-Party | Family | Single | 2-Party | Family | Single | 2-Party | Family | Single | 2-Party | Family |
| 0 - 19 | 72 | 130 | 190 | 63 | 112 | 164 | 56 | 101 | 148 | 52 | 94 | 138 |
| 20 - 24 | 77 | 147 | 204 | 66 | 127 | 177 | 60 | 114 | 159 | 55 | 106 | 148 |
| 25 - 29 | 88 | 167 | 254 | 76 | 144 | 219 | 69 | 130 | 198 | 64 | 121 | 184 |
| 30 - 34 | 101 | 191 | 308 | 87 | 165 | 267 | 79 | 149 | 241 | 73 | 138 | 223 |
| 35 - 39 | 109 | 194 | 353 | 94 | 168 | 305 | 85 | 151 | 275 | 79 | 141 | 255 |
| 40 - 44 | 125 | 229 | 412 | 108 | 198 | 356 | 98 | 178 | 321 | 91 | 165 | 298 |
| 45 - 49 | 145 | 272 | 465 | 125 | 235 | 403 | 113 | 212 | 363 | 105 | 197 | 337 |
| 50 - 54 | 167 | 323 | 492 | 144 | 279 | 425 | 130 | 252 | 384 | 121 | 234 | 356 |
| 55 - 59 | 199 | 396 | 537 | 172 | 343 | 465 | 155 | 309 | 419 | 144 | 287 | 389 |
| 60 - 64 | 242 | 490 | 626 | 209 | 423 | 542 | 189 | 382 | 489 | 175 | 354 | 453 |



| Deductibles | \$250 Medical | | | \$500 Medical | | | \$1,000 Medical | | | \$2,500 Medical | | |
|-------------|---------------|---------|--------|---------------|---------|--------|-----------------|---------|--------|-----------------|---------|--------|
| | \$100 Rx | | | \$200 Rx | | | \$400 Rx | | | \$1,000 Rx | | |
| Age | Single | 2-Party | Family | Single | 2-Party | Family | Single | 2-Party | Family | Single | 2-Party | Family |
| 0 - 19 | 79 | 141 | 207 | 68 | 122 | 179 | 61 | 110 | 161 | 57 | 102 | 150 |
| 20 - 24 | 83 | 159 | 222 | 72 | 138 | 192 | 65 | 124 | 173 | 60 | 115 | 161 |
| 25 - 29 | 96 | 181 | 276 | 83 | 157 | 238 | 75 | 141 | 215 | 69 | 131 | 200 |
| 30 - 34 | 110 | 207 | 335 | 95 | 179 | 290 | 86 | 162 | 261 | 79 | 150 | 243 |
| 35 - 39 | 118 | 211 | 383 | 102 | 183 | 331 | 92 | 165 | 299 | 86 | 153 | 277 |
| 40 - 44 | 136 | 248 | 448 | 118 | 215 | 387 | 106 | 194 | 349 | 98 | 180 | 324 |
| 45 - 49 | 158 | 296 | 506 | 136 | 256 | 438 | 123 | 231 | 395 | 114 | 214 | 366 |
| 50 - 54 | 181 | 351 | 535 | 157 | 303 | 462 | 141 | 274 | 417 | 131 | 254 | 387 |
| 55 - 59 | 216 | 431 | 584 | 187 | 372 | 505 | 168 | 336 | 455 | 156 | 312 | 423 |
| 60 - 64 | 263 | 532 | 681 | 227 | 460 | 589 | 205 | 415 | 531 | 190 | 385 | 493 |



| Deductibles | \$250 Medical | | | \$500 Medical | | | \$1,000 Medical | | | \$2,500 Medical | | |
|-------------|---------------|---------|--------|---------------|---------|--------|-----------------|---------|--------|-----------------|---------|--------|
| | \$100 Rx | | | \$200 Rx | | | \$400 Rx | | | \$1,000 Rx | | |
| Age | Single | 2-Party | Family | Single | 2-Party | Family | Single | 2-Party | Family | Single | 2-Party | Family |
| 0 - 19 | 88 | 157 | 230 | 76 | 136 | 199 | 68 | 122 | 179 | 63 | 113 | 166 |
| 20 - 24 | 93 | 177 | 247 | 80 | 153 | 214 | 72 | 138 | 193 | 67 | 128 | 179 |
| 25 - 29 | 107 | 202 | 307 | 92 | 175 | 265 | 83 | 157 | 239 | 77 | 146 | 222 |
| 30 - 34 | 122 | 231 | 373 | 106 | 200 | 323 | 95 | 180 | 291 | 88 | 167 | 270 |
| 35 - 39 | 132 | 235 | 427 | 114 | 203 | 369 | 103 | 183 | 333 | 95 | 170 | 309 |
| 40 - 44 | 151 | 277 | 499 | 131 | 239 | 431 | 118 | 216 | 389 | 110 | 200 | 361 |
| 45 - 49 | 175 | 329 | 563 | 152 | 285 | 487 | 137 | 257 | 439 | 127 | 238 | 408 |
| 50 - 54 | 201 | 391 | 595 | 174 | 338 | 515 | 157 | 305 | 464 | 146 | 283 | 431 |
| 55 - 59 | 240 | 479 | 650 | 208 | 415 | 562 | 187 | 374 | 507 | 174 | 347 | 470 |
| 60 - 64 | 293 | 592 | 758 | 253 | 512 | 655 | 228 | 462 | 591 | 212 | 429 | 549 |

70%/30% COINSURANCE OPTION
HMO MID-LEVEL PREMIUM RATES

No deductible for office visits. With deductible for Rx.



IHC MEDSM
A Product of IHC Health Plans

| Deductibles Age | \$250 Medical \$100 Rx | | | \$500 Medical \$200 Rx | | |
|--------------------|---------------------------|---------|--------|---------------------------|---------|--------|
| | Single | 2-Party | Family | Single | 2-Party | Family |
| 0 - 19 | 81 | 146 | 213 | 71 | 127 | 187 |
| 20 - 24 | 86 | 165 | 229 | 75 | 144 | 201 |
| 25 - 29 | 99 | 187 | 285 | 87 | 164 | 249 |
| 30 - 34 | 113 | 214 | 346 | 99 | 188 | 303 |
| 35 - 39 | 122 | 218 | 396 | 107 | 191 | 347 |
| 40 - 44 | 140 | 257 | 463 | 123 | 225 | 405 |
| 45 - 49 | 163 | 305 | 523 | 143 | 267 | 458 |
| 50 - 54 | 187 | 362 | 552 | 164 | 317 | 484 |
| 55 - 59 | 223 | 445 | 603 | 195 | 390 | 528 |
| 60 - 64 | 271 | 550 | 703 | 238 | 481 | 616 |



SELECTMEDSM
A Product of IHC Health Plans

| Deductibles Age | \$250 Medical \$100 Rx | | | \$500 Medical \$200 Rx | | |
|--------------------|---------------------------|---------|--------|---------------------------|---------|--------|
| | Single | 2-Party | Family | Single | 2-Party | Family |
| 0 - 19 | 87 | 156 | 229 | 78 | 139 | 204 |
| 20 - 24 | 92 | 177 | 246 | 82 | 157 | 219 |
| 25 - 29 | 106 | 201 | 306 | 95 | 179 | 272 |
| 30 - 34 | 122 | 230 | 372 | 108 | 205 | 331 |
| 35 - 39 | 131 | 234 | 425 | 117 | 208 | 378 |
| 40 - 44 | 151 | 276 | 497 | 134 | 245 | 442 |
| 45 - 49 | 175 | 328 | 561 | 155 | 292 | 499 |
| 50 - 54 | 201 | 389 | 593 | 179 | 346 | 527 |
| 55 - 59 | 239 | 478 | 647 | 213 | 425 | 576 |
| 60 - 64 | 291 | 590 | 755 | 259 | 525 | 672 |



IHC CARESM
A Product of IHC Health Plans

| Deductibles Age | \$250 Medical \$100 Rx | | | \$500 Medical \$200 Rx | | |
|--------------------|---------------------------|---------|--------|---------------------------|---------|--------|
| | Single | 2-Party | Family | Single | 2-Party | Family |
| 0-19 | 98 | 175 | 257 | 85 | 153 | 225 |
| 20 - 24 | 104 | 199 | 276 | 90 | 173 | 241 |
| 25 - 29 | 119 | 226 | 343 | 104 | 197 | 300 |
| 30 - 34 | 137 | 258 | 417 | 119 | 225 | 364 |
| 35 - 39 | 148 | 263 | 477 | 129 | 229 | 417 |
| 40 - 44 | 169 | 309 | 558 | 148 | 270 | 487 |
| 45 - 49 | 196 | 368 | 630 | 171 | 321 | 550 |
| 50 - 54 | 225 | 437 | 666 | 197 | 381 | 581 |
| 55 - 59 | 269 | 536 | 727 | 235 | 468 | 635 |
| 60 - 64 | 327 | 663 | 848 | 286 | 578 | 740 |

70%/30% COINSURANCE OPTION
HMO HIGH-LEVEL PREMIUM RATES

No deductible for office visits. No deductible for Rx.



| Deductible | \$250 Medical | | | \$500 Medical | | | \$1,000 Medical | | |
|------------|---------------|---------|--------|---------------|---------|--------|-----------------|---------|--------|
| | Single | 2-Party | Family | Single | 2-Party | Family | Single | 2-Party | Family |
| Age | | | | | | | | | |
| 0 - 19 | 91 | 163 | 238 | 80 | 143 | 209 | 74 | 133 | 195 |
| 20 - 24 | 96 | 184 | 256 | 84 | 161 | 225 | 78 | 150 | 209 |
| 25 - 29 | 111 | 209 | 318 | 97 | 183 | 279 | 90 | 171 | 260 |
| 30 - 34 | 127 | 239 | 387 | 111 | 210 | 339 | 103 | 195 | 316 |
| 35 - 39 | 137 | 244 | 442 | 120 | 214 | 388 | 112 | 199 | 361 |
| 40 - 44 | 157 | 287 | 517 | 137 | 251 | 453 | 128 | 234 | 422 |
| 45 - 49 | 182 | 341 | 584 | 159 | 299 | 512 | 148 | 279 | 477 |
| 50 - 54 | 209 | 405 | 617 | 183 | 355 | 541 | 171 | 331 | 504 |
| 55 - 59 | 249 | 497 | 674 | 218 | 436 | 591 | 203 | 406 | 550 |
| 60 - 64 | 303 | 614 | 786 | 266 | 538 | 689 | 248 | 501 | 642 |



| Deductible | \$250 Medical | | | \$500 Medical | | | \$1,000 Medical | | |
|------------|---------------|---------|--------|---------------|---------|--------|-----------------|---------|--------|
| | Single | 2-Party | Family | Single | 2-Party | Family | Single | 2-Party | Family |
| Age | | | | | | | | | |
| 0 - 19 | 97 | 175 | 256 | 87 | 155 | 228 | 79 | 142 | 208 |
| 20 - 24 | 103 | 198 | 275 | 92 | 176 | 245 | 84 | 161 | 224 |
| 25 - 29 | 119 | 225 | 342 | 106 | 200 | 304 | 97 | 183 | 278 |
| 30 - 34 | 136 | 257 | 415 | 121 | 229 | 370 | 111 | 209 | 338 |
| 35 - 39 | 147 | 262 | 475 | 131 | 233 | 423 | 119 | 213 | 386 |
| 40 - 44 | 168 | 308 | 555 | 150 | 274 | 494 | 137 | 250 | 451 |
| 45 - 49 | 195 | 366 | 627 | 174 | 326 | 558 | 159 | 298 | 510 |
| 50 - 54 | 224 | 435 | 663 | 200 | 387 | 590 | 182 | 353 | 539 |
| 55 - 59 | 268 | 534 | 723 | 238 | 475 | 644 | 217 | 434 | 588 |
| 60 - 64 | 326 | 659 | 844 | 290 | 587 | 751 | 265 | 536 | 686 |



| Deductible | \$250 Medical | | | \$500 Medical | | | \$1,000 Medical | | |
|------------|---------------|---------|--------|---------------|---------|--------|-----------------|---------|--------|
| | Single | 2-Party | Family | Single | 2-Party | Family | Single | 2-Party | Family |
| Age | | | | | | | | | |
| 0 - 19 | 109 | 196 | 287 | 96 | 171 | 251 | 88 | 158 | 232 |
| 20 - 24 | 116 | 222 | 309 | 101 | 194 | 270 | 93 | 179 | 249 |
| 25 - 29 | 134 | 252 | 384 | 117 | 221 | 335 | 108 | 203 | 309 |
| 30 - 34 | 153 | 289 | 466 | 133 | 252 | 407 | 123 | 232 | 376 |
| 35 - 39 | 165 | 294 | 533 | 144 | 257 | 466 | 133 | 237 | 430 |
| 40 - 44 | 189 | 346 | 623 | 165 | 302 | 545 | 152 | 279 | 502 |
| 45 - 49 | 219 | 411 | 704 | 192 | 359 | 615 | 177 | 331 | 567 |
| 50 - 54 | 252 | 488 | 744 | 220 | 427 | 650 | 203 | 393 | 599 |
| 55 - 59 | 300 | 599 | 812 | 262 | 524 | 710 | 242 | 483 | 654 |
| 60 - 64 | 366 | 740 | 947 | 320 | 647 | 828 | 295 | 597 | 763 |