



Kids Plans 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 Select Value, Select Med Plus, and Select Care Plus	NONPARTICIPATING BENEFITS Select Med Plus and Select Care Plus Only
DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM OPTIONS	Deductible/Out-of-Pocket Maximum \$150/\$2,000 \$500/\$2,000 \$1,000/\$3,000	Deductible/Out-of-Pocket Maximum \$500/\$4,000 \$750/\$5,000 \$1,500/\$6,000
COINSURANCE AND COPAYS Coinsurance (inpatient, outpatient) ³ Office Visit (PCP or SCP) ² Participating Emergency Room Visit Nonparticipating Emergency Room Visit	20% after deductible \$20 copay after deductible ¹ \$100 after deductible \$200 after deductible	40% after deductible 40% after deductible See "Participating Benefits" 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 Immunizations Elective Immunizations	Covered 100% 20%	Not covered Not covered
OUTPATIENT SERVICES Intermountain InstaCare SM Intermountain KidsCare SM Diagnostic Tests, Minor Diagnostic Tests, Major Physical, Speech, and Occupational Therapy (Up to 20 visits per calendar year)	\$30 after deductible ¹ \$20 after deductible ¹ Covered 100%, after deductible ¹ 20% after deductible \$20 after deductible	Not applicable Not applicable 40% after deductible 40% after deductible 40% after deductible
MENTAL HEALTH AND CHEMICAL DEPENDENCY⁴ Inpatient limited to ten days/calendar year Outpatient limited to 25 visits/calendar year	50% after deductible	50% after deductible
MISCELLANEOUS SERVICES Maternity and Adoption Infertility Chiropractic	Not covered Not covered Not covered	Not covered 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; \$500 annual maximum plan payment	Tier 1: \$10 Tier 2: 25% Tier 3: 50%	Tier 1: \$10 Tier 2: 25% Tier 3: 50%

BENEFIT SUMMARY FOOTNOTES:

1. Medical deductible waived when you select a high-level plan.
2. PCP (Primary Care Provider); SCP (Secondary Care Provider).
3. Coinsurance applies to inpatient and outpatient services, ambulance, home health, durable medical equipment, injectable drugs, and allergy treatment.
4. Mental health and chemical dependency costs are not applied to the out-of-pocket maximum.