



Transition Benefit Summary

The same level of benefits applies to all providers. Select Care providers will not bill you for excess charges. Nonparticipating providers may bill you for excess charges.

OPTIONAL BENEFITS

Deductible <i>Deductible is not included in the maximum coinsurance</i>	\$250 individual/\$750 family \$500 individual/\$1,500 family \$1,000 individual/\$2,500 family \$2,500 individual/\$5,000 family
Coinsurance/Maximum Coinsurance	20% coinsurance/\$1,000 maximum coinsurance 50% coinsurance/\$2,500 maximum coinsurance

STANDARD BENEFITS

Lifetime Maximum Plan Payment	\$1,000,000
Pre-existing Conditions	Not Covered
Inpatient Services Hospital admissions Skilled nursing facility <i>(up to 40 days per plan term)</i> Rehabilitation therapy <i>(up to 30 days per plan term)</i>	Coinsurance after deductible
Office Services Office Visits Office Surgeries Intermountain InstaCare SM /Urgent Care Intermountain KidsCare SM Diagnostic Tests Allergy Tests and Treatment	Coinsurance after deductible
Outpatient Services Outpatient Surgery Diagnostic Tests Physical, Speech, and Occupational Therapy <i>(up to 20 visits each per plan term)</i>	Coinsurance after deductible



STANDARD BENEFITS CONTINUED

Miscellaneous Services Emergency Room Ambulance Home Health Durable Medical Equipment Injectable Drugs Chiropractic Services <i>(up to 5 visits per plan term)</i>	Coinsurance after deductible
Noncovered Services Preventive Care Mental Health and Chemical Dependency Maternity and Adoption	Not covered
Prescription Drugs	Not covered