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| | MEMBER PAYMENT SUMMARY | |
|---|---|---|
| | **PARTICIPATING** *(In-Network)* When using participating providers, you are responsible to pay the amounts in this column. | **NONPARTICIPATING** *(Out-of-Network)* When using nonparticipating providers, you are responsible to pay the amounts in this column. |
| **CONDITIONS AND LIMITATIONS** | | |
| Lifetime Maximum Plan Payment - *Per Person* | None | |
| Pre-Existing Conditions (PEC) | None | |
| Benefit Accumulator Period | plan year | |
| Maximum Annual Out-of-Network Payment - (per plan year) | None | None |
| **MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET** | **PARTICIPATING** | **NONPARTICIPATING** |
| Deductible - Per Person/Family (per plan year) | $1000/$2000 | $2000/$4000 |
| Total Out-of-Pocket Maximum - Per Person/Family (per plan year) | $3000/$6000 | $6000/$12000 |
| (Medical and Pharmacy Included in the Out-of-Pocket Maximum) | | |
| **INPATIENT SERVICES** | **PARTICIPATING** | **NONPARTICIPATING** |
| Medical, Surgical and Hospice [4] | 20% after deductible | 40% after deductible |
| Skilled Nursing Facility [4] - Up to 60 days per plan year | 20% after deductible | 40% after deductible |
| Inpatient Rehab Therapy: Physical, Speech, Occupational [4] | 20% after deductible | 40% after deductible |
| Up to 40 days per plan year for all therapy types combined | | |
| **PROFESSIONAL SERVICES** | **PARTICIPATING** | **NONPARTICIPATING** |
| Office Visits & Minor Office Surgeries | | |
| Primary Care Provider (PCP) [1] | $15 | 40% after deductible |
| Secondary Care Provider (SCP) [1] | $20 | 40% after deductible |
| Allergy Tests | See Office Visits Above | Not Covered |
| Allergy Treatment and Serum | 20% | Not Covered |
| Major Office Surgery *(Surgical and Endoscopic Services Over $350)* | 20% | 40% after deductible |
| Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)* | 20% after deductible | 40% after deductible |
| **PREVENTIVE SERVICES AS OUTLINED BY THE ACA [2,3]** | **PARTICIPATING** | **NONPARTICIPATING** |
| Primary Care Provider (PCP) [1] | Covered 100% | Not Covered |
| Secondary Care Provider (SCP) [1] | Covered 100% | Not Covered |
| Adult and Pediatric Immunizations | Covered 100% | Not Covered |
| Elective Immunizations - herpes zoster (shingles), rotavirus | Covered 100% | Not Covered |
| Diagnostic Tests: Minor | Covered 100% | Not Covered |
| Other Preventive Services | Covered 100% | Not Covered |
| **OUTPATIENT SERVICES [4]** | **PARTICIPATING** | **NONPARTICIPATING** |
| Outpatient Facility and Ambulatory Surgical | 20% after deductible | 40% after deductible |
| Ambulance (Air or Ground) - *Emergencies Only* | 20% after deductible | See Participating Benefit |
| Emergency Room - *(Participating facility)* | $75 after deductible | See Participating Benefit |
| Emergency Room - *(Nonparticipating facility)* | $75 after deductible | See Participating Benefit |
| Intermountain InstaCare® Facilities, Urgent Care Facilities | $30 | 40% after deductible |
| Intermountain KidsCare® Facilities | $15 | 40% after deductible |
| Chemotherapy, Radiation and Dialysis | 20% after deductible | 40% after deductible |
| Diagnostic Tests: Minor [2] | Covered 100% | 40% after deductible |
| Diagnostic Tests: Major [2] | 20% after deductible | 40% after deductible |
| Home Health, Hospice, Outpatient Private Nurse | 20% after deductible | 40% after deductible |
| Outpatient Rehab Therapy: Physical, Speech, Occupational | $20 after deductible | 40% after deductible |
| *Up to 20 visits per plan year for each therapy type* | | |



*See other side for additional benefits*

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| | MEMBER PAYMENT SUMMARY | |
|---|---|---|
| | **PARTICIPATING** *(In-Network)* | **NONPARTICIPATING** *(Out-of-Network)* |
| **MISCELLANEOUS SERVICES** | **PARTICIPATING** | **NONPARTICIPATING** |
| Durable Medical Equipment (DME) [4] | 20% after deductible | 40% after deductible |
| Miscellaneous Medical Supplies (MMS) [3] | 20% after deductible | 40% after deductible |
| Maternity and Adoption [4,5] | See Professional, Inpatient or Outpatient | 40% after deductible |
| Cochlear Implants [4] | See Professional, Inpatient or Outpatient | Not Covered |
| Infertility - *Select Services* | *50% after deductible | Not Covered |
| *(Max Plan Payment $1,500/ plan year; $5,000 lifetime)* | | |
| Donor Fees for Covered Organ Transplants [4] | 20% after deductible | Not Covered |
| TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime* | See Professional, Inpatient or Outpatient | Not Covered |
| **BENEFIT RIDERS** | **PARTICIPATING** | **NONPARTICIPATING** |
| Mental Health and Chemical Dependency [4] | | |
| Mental Health Office Visits | $15 | 40% after deductible |
| Inpatient | 20% after deductible | 40% after deductible [4] |
| Outpatient | 20% | 40% after deductible [4] |
| Residential Treatment [2] | 20% after deductible | 40% after deductible [4] |
| Chiropractic - In Utah call 800-678-9133, in Idaho use BrightPath, | *$15 (up to 20 visits per plan year) | Not Covered |
| outside Utah and Idaho use MultiPlan/PHCS | | |
| Injectable Drugs and Specialty Medications [4] | 20% after deductible | 40% after deductible |
| **PRESCRIPTION DRUGS** | | |
| Prescription Drug List (formulary) | RxSelect® | |
| Prescription Drugs - *Up to 30 Day Supply of Covered Medications* [4] | | |
| Tier 1 | $10 | |
| Tier 2 | $25 | |
| Tier 3 | $45 | |
| Tier 4 | $100 | |
| Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90® )-selected drugs* [4] | | |
| Tier 1 | $10 | |
| Tier 2 | $50 | |
| Tier 3 | $135 | |
| Generic Substitution Required | Generic required or must pay copay plus cost difference between name brand and generic | |

To remain compliant with state and federal regulations including the Affordable Care Act (ACA), these benefits are subject to change.

1 Refer to **selecthealth.org/findadoctor** to identify whether a provider is a primary or secondary care provider.

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some preventive care and MMS services.

4 Preauthorization is required for the following: (a) all inpatient services; (b) certain injectable drugs and specialty medications; (c) certain prescription drugs; (d) certain DME items; (e) certain mental health and chemical dependency services; (f) maternity stays longer than two days for normal delivery or longer than four days for cesarean; (g) home health nursing; and (h) pain management/pain clinic services. Benefits may be reduced or denied if you do not preauthorize certain services. Please refer to Section 11-- "Healthcare Management", in your Certificate of Coverage, for details.

5 SelectHealth provides a $4000 adoption indemnity as outlined by the state of Utah. Medical deductible, copay, or coinsurance listed under the benefit applies and may exhaust the benefits prior to any plan payments.

* Not applied to Medical out-of-pocket maximum.

All covered services obtained outside the United States, except for routine, urgent, or emergency conditions require preauthorization.

*All deductible/copay/coinsurance amounts are based on the allowed amounts and not on the provider's billed charges. You are responsible to pay for excess charges on covered services obtained from non-participating providers and facilities. Excess charges are not applied to the medical out-of-pocket maximums.*
*For more information, call Member Services at 800-538-5038 weekdays, from 7:00 a.m.to 8:00 p.m., and Saturdays from 9:00 a.m. to 2:00 p.m.*

*Select Care Plus benefits are administered and underwritten by SelectHealth.*

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| | MEMBER PAYMENT SUMMARY | |
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| **CONDITIONS AND LIMITATIONS** | | |
| Lifetime Maximum Plan Payment - *Per Person* | None | |
| Pre-Existing Conditions (PEC) | None | |
| Benefit Accumulator Period | plan year | |
| Maximum Annual Out-of-Network Payment - (per plan year) | None | None |
| **MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET** | **PARTICIPATING** | **NONPARTICIPATING** |
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| **MISCELLANEOUS SERVICES** | **PARTICIPATING** | **NONPARTICIPATING** |
| Durable Medical Equipment (DME) [4] | 20% after deductible | 40% after deductible |
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| Residential Treatment [2] | 20% after deductible | 40% after deductible [4] |
| Chiropractic - 800-678-9133 | *$15 (up to 20 visits per plan year) | Not Covered |
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| **PRESCRIPTION DRUGS** | | |
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