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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[5]	**PARTICIPATING**	**NONPARTICIPATING**
Deductible - Per Person/Family (per plan year)	$2000/$4000	$3000/$6000
Total Out-of-Pocket Maximum - Per Person/Family (per plan year) (Medical and Pharmacy Included in the Out-of-Pocket Maximum)	$5000/$10000	$10000/$20000
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] Up to 40 days per plan year for all therapy types combined	20% after deductible	40% after deductible
PROFESSIONAL SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	$30	40% after deductible
Secondary Care Provider (SCP)[1]	$60	40% after deductible
Allergy Tests	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Major Surgery	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)*	$300	See Participating Benefit
Emergency Room - *(Nonparticipating facility)*	$300	See Participating Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$60	40% after deductible
Intermountain KidsCare® Facilities	$30	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 *Up to 20 visits per plan year for each therapy type*	$60 after deductible	40% after deductible

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
Autism Spectrum Disorder *Applied behavior analysis and behavioral health services up to $30,000 or 600 hours/plan year, whichever is greater*	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity and Adoption[4,6]	See Professional, Inpatient or Outpatient	40% after deductible
Cochlear Implants[4]	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services* *(Max Plan Payment $1,500/ plan year; $5,000 lifetime)*	*50% after deductible	Not Covered
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
OPTIONAL BENEFITS	**PARTICIPATING**	**NONPARTICIPATING**
Mental Health and Chemical Dependency[4]		
Mental Health Office Visits	$30	40% after deductible
Inpatient	20% after deductible	40% after deductible
Outpatient	20%	40% after deductible
Residential Treatment[2]	20% after deductible	40% after deductible
Chiropractic - 800-678-9133	*$30 (up to 15 visits per plan year)	Not Covered
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: all inpatient services; certain injectable drugs and specialty medications; certain prescription drugs; certain DME items and prosthetic items; certain mental health and chemical dependency services; maternity stays longer than two days for normal delivery or longer than four days for cesarean and all deliveries outside of the service area; home health nursing; pain management/pain clinic services; outpatient private nurse; organ transplants; cochlear implants and certain genetic tests. 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 All deductible/copay/coinsurance amounts are based on the allowed amounts and not on the providers billed charges. Nonparticipating Providers or Facilities have not agreed to accept the Allowed Amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

6 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.

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 Med Plus benefits are administered and underwritten by SelectHealth.