



Medical Plan Option 2

EFFECTIVE 01/01/10 THROUGH 12/31/10

	Select Care \$0 Deductible Current	Select Care \$0 Deductible Proposed
Employee	\$440.00	\$486.00
Ee+Spouse	\$879.00	\$971.00
Ee+Child(ren)	\$768.00	\$848.00
Family	\$1,319.00	\$1,457.00

Approximate Renewal Increase 10.4%

	Select Care \$1,000 Deductible Current	Select Care \$1,000 Deductible Proposed
Employee	\$260.00	\$291.00
Ee+Spouse	\$521.00	\$584.00
Ee+Child(ren)	\$457.00	\$512.00
Family	\$779.00	\$873.00

Approximate Renewal Increase 12.1%

Please provide a client signature on the sold rate sheet and initial the correlating Member Payment Summaries. Fax all documents to the attention of your LE Sales Representative at 801-442-5003.

Note that member materials will NOT be ordered until the final rates and plan designs are confirmed. **Employer contribution may be subject to verification by SelectHealth.*

Client Signature _____ Date _____



MEMBER PAYMENT SUMMARY

PARTICIPATING

(In-Network)

When using participating providers, you are responsible to pay the amounts in this column. Services from nonparticipating providers are not covered (except emergencies).

CONDITIONS AND LIMITATIONS	
Lifetime Maximum Plan Payment - <i>Per Person</i>	\$2,500,000
Pre-Existing Conditions (PEC)	None
Benefit Accumulator Period	calendar year
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET	
Deductible - Per Person/Family (per calendar year)	No Deductible
Out-of-Pocket Maximum - Per Person/Family (per calendar year)	\$1500/\$3000
INPATIENT SERVICES	
Medical, Surgical, Hospice, and Emergency Admissions	20%
Maternity and Adoption ¹	20%
Skilled Nursing Facility - Up to 60 days per calendar year	20%
Inpatient Rehab Therapy: Physical, Speech, Occupational	20%
Up to 40 days per calendar year for all therapy types combined	
PROFESSIONAL SERVICES	
Office Visits & Minor Office Surgeries	
Primary Care Provider (PCP) ²	\$20
Secondary Care Provider (SCP) ²	\$35
Preventive Care	
Primary Care Provider (PCP) ²	\$20
Secondary Care Provider (SCP) ²	\$35
Adult and Pediatric Immunizations	Covered 100%
Elective Immunizations - herpes zoster (shingles), rotavirus	20%
Diagnostic Tests: Minor ³	Covered 100%
Allergy Tests	See Office Visits Above
Allergy Treatment and Serum	20%
Major Office Surgery (<i>Surgical and Endoscopic Services Over \$350</i>)	20%
Physician's Fees - (<i>Medical, Surgical, Maternity, Anesthesia</i>)	20%
OUTPATIENT SERVICES	
Outpatient Facility and Ambulatory Surgical - (<i>all related services</i>)	20%
Ambulance (Air or Ground) - <i>Emergencies Only</i>	20%
Emergency Room - (<i>Participating facility</i>) - Includes all services rendered in conjunction with the ER	\$100
Emergency Room - (<i>Nonparticipating facility</i>) - Includes all services rendered in conjunction with the ER	\$150
Intermountain InstaCare SM Facilities, Urgent Care Facilities	\$35
Intermountain KidsCare SM Facilities	\$20
Chemotherapy, Radiation and Dialysis	20%
Diagnostic Tests: Minor ³	Covered 100%
Diagnostic Tests: Major ³	20%
Home Health, Hospice, Outpatient Private Nurse	20%
Outpatient Rehab Therapy: Physical, Speech, Occupational	\$35
Up to 20 visits per calendar year for each therapy type	



MEMBER PAYMENT SUMMARY

PARTICIPATING
(In-Network)

MISCELLANEOUS SERVICES	PARTICIPATING
Durable Medical Equipment (DME) ⁴	20%
Infertility - <i>Selected Services</i>	*50%
<i>(Max Plan Payment \$1,500/ calendar year; \$5,000 lifetime)</i>	
Miscellaneous Medical Supplies (MMS)	20%
Other Plan Payment Maximums	
Cochlear Implants - <i>Up to \$35,000 lifetime</i>	See Physician's Fees and Inpatient or Outpatient Services benefits
Donor Fees for Covered Organ Transplants - <i>Up to \$40,000 lifetime</i>	20%
TMJ (Temporomandibular Joint) Services - <i>Up to \$2,000 lifetime</i>	20%
BENEFIT RIDERS	PARTICIPATING
Mental Health and Chemical Dependency ⁷	
Mental Health Office Visits	\$20
Inpatient	20%
Outpatient	20%
Residential Treatment ⁷	20%
Injectable Drugs and Specialty Medications +	20%
PRESCRIPTION DRUGS	
Prescription Drugs - <i>Up to 30 Day Supply of Covered Medications</i> +	
Tier 1	*\$5
Tier 2	*\$20
Tier 3	*\$40
Maintenance Drug Benefit-90 Day Supply (Medco by Mail or Retail ^{90SM})- <i>selected drugs</i> +	
Tier 1	*\$5
Tier 2	*\$40
Tier 3	*\$120
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic

- 1 SelectHealth provides an allowable adoption amount of \$4,000 as outlined by the state of Utah. Medical deductible and copay/coinsurance applies.
- 2 Refer to your SelectHealth Provider & Facility Directory to identify whether a provider is a primary or secondary care provider.
- 3 Refer to your Certificate of Coverage for more information.
- 4 Certain DME items require preauthorization for coverage. Refer to your Certificate of Coverage, or contact SelectHealth Member Services for more information.
- 7 All mental health and chemical dependency services require preauthorization with the exception of office visits.
- + Preauthorization is required on certain injectable and prescription drugs. If you fail to preauthorize, the drug will not be covered. Please refer to your Certificate of Coverage for more information.
- * Not applied to Medical out-of-pocket maximum.

All deductible/copay/coinsurance amounts and plan payments are based on allowed amounts only and not on the provider's billed or other charges. You are responsible to pay for charges in excess of allowed amounts for covered services obtained from non-participating providers and facilities. Such excess charges are not applied to the medical out-of-pocket maximum. Refer to your Contract, Certificate of Coverage, or Provider & Facility Directory for more information.

Select Care is administered and underwritten by SelectHealth.



MEMBER PAYMENT SUMMARY

PARTICIPATING

(In-Network)

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CONDITIONS AND LIMITATIONS	
Lifetime Maximum Plan Payment - <i>Per Person</i>	\$2,500,000
Pre-Existing Conditions (PEC)	None
Benefit Accumulator Period	calendar year
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET	
Deductible - Per Person/Family (per calendar year)	\$1000/\$2000
Out-of-Pocket Maximum - Per Person/Family (per calendar year)	\$5000/\$10000 (Deductible Included)
INPATIENT SERVICES	
Medical, Surgical, Hospice, and Emergency Admissions	20% after deductible
Maternity and Adoption ¹	20% after deductible
Skilled Nursing Facility - Up to 60 days per calendar year	20% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational Up to 40 days per calendar year for all therapy types combined	20% after deductible
PROFESSIONAL SERVICES	
Office Visits & Minor Office Surgeries	
Primary Care Provider (PCP) ²	\$15 after deductible
Secondary Care Provider (SCP) ²	\$25 after deductible
Preventive Care	
Primary Care Provider (PCP) ²	\$15 after deductible
Secondary Care Provider (SCP) ²	\$25 after deductible
Adult and Pediatric Immunizations	Covered 100%
Elective Immunizations - herpes zoster (shingles), rotavirus	20%
Diagnostic Tests: Minor ³	Covered 100% after deductible
Allergy Tests	See Office Visits Above
Allergy Treatment and Serum	20% after deductible
Major Office Surgery (<i>Surgical and Endoscopic Services Over \$350</i>)	20% after deductible
Physician's Fees - (<i>Medical, Surgical, Maternity, Anesthesia</i>)	20% after deductible
OUTPATIENT SERVICES	
Outpatient Facility and Ambulatory Surgical - (<i>all related services</i>)	20% after deductible
Ambulance (Air or Ground) - <i>Emergencies Only</i>	20% after deductible
Emergency Room - (<i>Participating facility</i>) - Includes all services rendered in conjunction with the ER	\$50 after deductible
Emergency Room - (<i>Nonparticipating facility</i>) - Includes all services rendered in conjunction with the ER	\$100 after deductible
Intermountain InstaCare SM Facilities, Urgent Care Facilities	\$25 after deductible
Intermountain KidsCare SM Facilities	\$15 after deductible
Chemotherapy, Radiation and Dialysis	20% after deductible
Diagnostic Tests: Minor ³	Covered 100% after deductible
Diagnostic Tests: Major ³	20% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational <i>Up to 20 visits per calendar year for each therapy type</i>	\$25 after deductible



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Durable Medical Equipment (DME) ⁴	20% after deductible
Infertility - <i>Selected Services</i>	*50% after deductible
<i>(Max Plan Payment \$1,500/ calendar year; \$5,000 lifetime)</i>	
Miscellaneous Medical Supplies (MMS)	20% after deductible
Other Plan Payment Maximums	
Cochlear Implants - <i>Up to \$35,000 lifetime</i>	See Physician's Fees and Inpatient or Outpatient Services benefits
Donor Fees for Covered Organ Transplants - <i>Up to \$40,000 lifetime</i>	20% after deductible
TMJ (Temporomandibular Joint) Services - <i>Up to \$2,000 lifetime</i>	20% after deductible
BENEFIT RIDERS	PARTICIPATING
Mental Health and Chemical Dependency ⁷	
Mental Health Office Visits	\$15 after deductible
Inpatient	20% after deductible
Outpatient	20% after deductible
Residential Treatment ⁷	20% after deductible
Injectable Drugs and Specialty Medications +	20% after deductible
PRESCRIPTION DRUGS	
Prescription Drugs - <i>Up to 30 Day Supply of Covered Medications</i> +	
Tier 1	*\$5
Tier 2	*\$20
Tier 3	*\$40
Maintenance Drug Benefit-90 Day Supply (Medco by Mail or Retail ^{90SM})- <i>selected drugs</i> +	
Tier 1	*\$5
Tier 2	*\$40
Tier 3	*\$120
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic
Supplemental Accident - <i>Deductible, copay & coinsurance apply thereafter</i> <i>(per person per calendar year within 1 year of accident)</i>	Covered 100% for 1st \$1000

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- + Preauthorization is required on certain injectable and prescription drugs. If you fail to preauthorize, the drug will not be covered. Please refer to your Certificate of Coverage for more information.
- * Not applied to Medical out-of-pocket maximum.
- Supplemental Accident benefit does not apply to Chiropractic Services.

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