

This Plan intends to meet grandfathered status requirements set forth in the Affordable Care Act (ACA).



**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).

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



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MISCELLANEOUS SERVICES	PARTICIPATING
Durable Medical Equipment (DME) <sup>4</sup>	20%
Miscellaneous Medical Supplies (MMS)	20%
Cochlear Implants - <i>Up to \$35,000 lifetime</i>	See Physician's Fees and Inpatient or Outpatient Services benefits
Infertility - <i>Selected Services</i> <i>(Max Plan Payment \$1,500/ calendar year; \$5,000 lifetime)</i>	*50%
Donor Fees for Covered Organ Transplants - <i>Up to \$40,000 per transplant</i>	20%
TMJ (Temporomandibular Joint) Services - <i>Up to \$2,000 lifetime</i>	See Physician's Fees and Inpatient or Outpatient Services benefits
BENEFIT RIDERS	PARTICIPATING
Mental Health and Chemical Dependency <sup>4</sup>	
Mental Health Office Visits	\$20
Inpatient	20%
Outpatient	20%
Residential Treatment	20%
Injectable Drugs and Specialty Medications <sup>4</sup>	20%
PRESCRIPTION DRUGS	
Prescription Drug List (formulary)	RxSelect <sup>SM</sup>
Prescription Drugs - <i>Up to 30 Day Supply of Covered Medications</i> <sup>4</sup>	
Tier 1	*\$5
Tier 2	*\$20
Tier 3	*\$40
Maintenance Drug Benefit-90 Day Supply (Medco by Mail or Retail <sup>SM</sup> )- <i>selected drugs</i> <sup>4</sup>	
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

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- 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 Preauthorization is required for the following: (a) certain injectable drugs and specialty medications; (b) certain prescription drugs; (c) certain DME items; (d) certain mental health and chemical dependency services.; and (e) all services obtained outside the United States unless for a routine, urgent, or emergent condition. Please refer to your Certificate of Coverage or call Member Services 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.

MPS-HMO 10/01/10  
10/28/10

[www.selecthealth.org](http://www.selecthealth.org)

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



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Infertility - <i>Selected Services</i> <i>(Max Plan Payment \$1,500/ calendar year; \$5,000 lifetime)</i>	*50% after deductible
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TMJ (Temporomandibular Joint) Services - <i>Up to \$2,000 lifetime</i>	See Physician's Fees and Inpatient or Outpatient Services benefits
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Tier 3	*\$40
Maintenance Drug Benefit-90 Day Supply (Medco by Mail or Retail90 <sup>SM</sup> )- <i>selected drugs</i> <sup>4</sup>	
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 &amp; 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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Supplemental Accident benefit does not apply to Chiropractic Services.

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