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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 - *Per Person*: None
Pre-Existing Conditions (PEC): None
Benefit Accumulator Period: calendar year
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5] — **PARTICIPATING**
Self Only Coverage, 1 person enrolled - per calendar year
Deductible: $150
Out-of-Pocket Maximum: $1,500
Family Coverage, 2 or more enrolled - per calendar year
Deductible - per person/family: $150/$300
Out-of-Pocket Maximum - per person/family: $1500/$3000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)
INPATIENT SERVICES — **PARTICIPATING**
Medical, Surgical and Hospice[4]: $250 per admit, then Covered 100% after deductible
Skilled Nursing Facility[4] - Up to 60 days per calendar year: $250 per admit, then Covered 100% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]: Covered 100% after deductible
Up to 40 days per calendar year for all therapy types combined
PROFESSIONAL SERVICES — **PARTICIPATING**
Office Visits & Minor Office Surgeries
Primary Care Provider (PCP)[1]: $20
Secondary Care Provider (SCP)[1]: $35
Allergy Tests: See Office Visits Above
Allergy Treatment and Serum: Covered 100%
Major Surgery: Covered 100%
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*: Covered 100% after deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3] — **PARTICIPATING**
Primary Care Provider (PCP)[1]: Covered 100%
Secondary Care Provider (SCP)[1]: Covered 100%
Adult and Pediatric Immunizations: Covered 100%
Elective Immunizations - herpes zoster (shingles), rotavirus: Covered 100%
Diagnostic Tests: Minor: Covered 100%
Other Preventive Services: Covered 100%
VISION SERVICES — **PARTICIPATING**
Preventive Eye Exams: Covered 100%
All Other Eye Exams: $35
OUTPATIENT SERVICES[4] — **PARTICIPATING**
Outpatient Facility and Ambulatory Surgical: $35 after deductible
Ambulance (Air or Ground) - *Emergencies Only*: Covered 100% after deductible
Emergency Room - *(Participating facility)*: $100 after deductible
Emergency Room - *(Nonparticipating facility)*: $100 after deductible
Intermountain InstaCare® Facilities, Urgent Care Facilities: $35
Intermountain KidsCare® Facilities: $20
Intermountain Connect Care®: $10
Chemotherapy, Radiation and Dialysis: Covered 100% after deductible
Diagnostic Tests: Minor[2]: Covered 100%
Diagnostic Tests: Major[2]: $50 after deductible
Home Health, Hospice, Outpatient Private Nurse: Covered 100% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational: $20 after deductible
Up to 20 visits per calendar year for each therapy type

See other side for additional benefits

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MEMBER PAYMENT SUMMARY

PARTICIPATING
(In-Network)

MISCELLANEOUS SERVICES	PARTICIPATING
Durable Medical Equipment (DME)[4]	Covered 100% after deductible
Miscellaneous Medical Supplies (MMS)[3]	Covered 100% after deductible
Autism Spectrum Disorder *Applied behavior analysis and behavioral health services up to $30,000 or 600 hours/calendar year, whichever is greater*	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity and Adoption[4,6]	See Professional, Inpatient or Outpatient
Cochlear Implants[4]	See Professional, Inpatient or Outpatient
Infertility - *Select Services* *(Max Plan Payment $1,500/ calendar year; $5,000 lifetime)*	*50% after deductible
Donor Fees for Covered Organ Transplants[4]	Covered 100% after deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient
OPTIONAL BENEFITS	**PARTICIPATING**
Mental Health and Chemical Dependency[4]	
Office Visits	$20
Inpatient	$250 per admit, then Covered 100% after deductible
Outpatient	Covered 100%
Residential Treatment[2]	$250 per admit, then Covered 100% after deductible
Chiropractic - 800-678-9133	*$20 (up to 15 visits per calendar year)
Injectable Drugs and Specialty Medications[4]	Covered 100% 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	$120
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; certain genetic tests; surgeries on vertebral bodies, vertebral joints, spinal discs; joint replacements; hysterectomy; adenoidectomy; and tonsillectomy. 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.

To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.

Select Med is administered and underwritten by SelectHealth.