INDIVIDUAL PLANS I30C0077

	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*	$2,500,000	$1,000,000
In total, the benefit may not exceed the participating maximum		
Maximum Annual Out-Of-Network Payment (per calendar year)[6]	None	$500,000
Pre-Existing Conditions (PEC) and Limitations [1]	Not covered first 12 months	
Waived (entirely or partly) for qualifying pre-exisiting condition credit	*(18 months for late enrollees)*	
DEDUCTIBLE AND OUT-OF-POCKET	**PARTICIPATING**	**NONPARTICIPATING**
Calendar Year Deductible and Out-of-Pocket Maximum		
Deductible	$10,000	$15,000
The entire deductible must be met before benefits are paid		
Out-of-Pocket Maximum	$10,000	$15,000
Deductible is included in the Out-of-Pocket Maximum		
INPATIENT SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Medical, Surgical, Hospice, and Emergency Admissions	Covered 100% after deductible	Covered 100% after deductible with precert [5]
Semi-private room, anesthesia, and all related services		
Maternity and Adoption	Not Covered	Not Covered
Skilled Nursing Facility	Covered 100% after deductible	Covered 100% after deductible with precert [5]
Up to 60 days/calendar year		
Rehab Therapy: Physical, Speech, Occupational	Covered 100% after deductible	Covered 100% after deductible with precert [5]
Up to 40 days/calendar year for all therapy types combined		
PROFESSIONAL SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Office Visits & Office Surgeries		
Primary Care Provider (PCP) [1]	Covered 100% after deductible	Covered 100% after deductible
Secondary Care Provider (SCP) [1]	Covered 100% after deductible	Covered 100% after deductible
Preventive Care Office Visits		
Primary Care Provider (PCP) [1]	$15 Copay	Not Covered
Secondary Care Provider (SCP) [1]	$25 Copay	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations[2]	Covered 100%	Not Covered
Diagnostic Tests, Minor[2]	Covered 100%	
Allergy Tests	See office visits	Not Covered
Allergy Treatment and Serum	Covered 100% after deductible	Not Covered
Physician's Fees - *Medical, Surgical, Anesthesia*	Covered 100% after deductible	Covered 100% after deductible with precert [5]
OUTPATIENT SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Outpatient Facility and Ambulatory Surgical - *Includes all related facility services*	Covered 100% after deductible	Covered 100% after deductible with precert [5]
Ambulance (Air or Ground) - *emergencies only*	Covered 100% after deductible	See Participating Benefit
Emergency Room Participating Facility	Covered 100% after deductible	See Participating Benefit
Includes all facility services rendered in conjunction with the ER		
Emergency Room Nonparticipating Facility	Covered 100% after deductible	See Participating Benefit
Includes all facility services rendered in conjunction with the ER		
Intermountain InstaCare[SM] Facilities, Urgent Care Facilities	Covered 100% after deductible	Covered 100% after deductible
Intermountain KidsCare[SM] Facilities	Covered 100% after deductible	Not Available
Chemotherapy, Radiation and Dialysis	Covered 100% after deductible	Covered 100% after deductible
Diagnostic Tests: Minor [2]	Covered 100% after deductible	Covered 100% after deductible
Diagnostic Tests: Major [2]	Covered 100% after deductible	Covered 100% after deductible with precert [5]
Home Health, Hospice, Outpatient Private Nurse	Covered 100% after deductible	Covered 100% after deductible with precert [5]
Outpatient Rehab Therapy: Physical, Speech, Occupational	Covered 100% after deductible	Covered 100% after deductible
Up to 20 visits/calendar year for each therapy type		

See next page for additional benefits and footnotes.

MISCELLANEOUS SERVICES	PARTICIPATING	NONPARTICIPATING
Chiropractic Care	Not Covered	Not Covered
Durable Medical Equipment (DME) [7]	Covered 100% after deductible	Covered 100% after deductible with precert
Maximum plan payment; up to $1,500/calendar year		
Infertility (*Select services only*) [2]	Covered 100% after deductible	Not Covered
Up to $1,500/calendar year; $5,000/lifetime		
Injectable drugs and Specialty Medications [4]	Covered 100% after deductible	Covered 100% after deductible
Miscellaneous Medical Supplies (MMS)	Covered 100% after deductible	Covered 100% after deductible
Mental Health and Chemical Dependency		
Inpatient - Up to 10 days/calendar year	Covered 100% after deductible	Covered 100% after deductible with precert [5]
Outpatient - Up to 25 days/calendar year	Covered 100% after deductible	Covered 100% after deductible

PRESCRIPTION DRUGS	
Prescription Drugs [4]	
Tier 1	Covered 100% after deductible
Tier 2	Covered 100% after deductible
Tier 3	Covered 100% after deductible
Up to a 30-day supply for covered medications; generic substitution required	
Maintenance Drug Benefit - 90-Day Supply (Medco by Mail or Retail 90℠)[4]	
Tier 1	Covered 100% after deductible
Tier 2	Covered 100% after deductible
Tier 3	Covered 100% after deductible

FOOTNOTES

1. Refer to your SelectHealth Provider & Facility Directory to identify whether a provider is a Primary Care or Secondary Care Provider.
2. Refer to the Contract for more information.
3. Deductible will not apply for Preventive Care services.
4. Preauthorization is required on certain injectable and prescription drugs. Please refer to your Contract or call Member Services for more information.
5. Precertification is required for all the following: inpatient services; maternity stays longer than two days for a normal delivery or longer than four days for a cesarean; home health nursing services; and pain management/pain clinic services. If you fail to precertify, benefits are reduced to 50 percent and will not be applied to your out-of-pocket maximum.
6. Dollar amount applied to the Maximum Annual Out-Of-Network Payment is also applied to the Lifetime Maximum Plan Payment.
7. DME is limited to the cost of the item(s) up to the annual DME maximum. Certain DME items are exclued from the annual DME maximum and require prior notification or precertification for coverage. Refer to your Contract, or contact SelectHealth Member Services for additional information.

All deductible/copay/coinsurance amounts are based on eligible charges and not on the provider's billed charges. You are responsible to pay for excess charges on covered services from nonparticipating providers and facilities. Excess charges are not applied to the out-of-pocket maximums. Refer to your contract or Provider & Facility Directory for more information.

Participating Benefits are administered and underwritten by SelectHealth. Nonparticipating benefits are administered by Select Health and Underwritten by SelectHealth Benefit Assurance Company.