



PARTICIPATING	NONPARTICIPATING
(In-Network) When using participating providers, you are responsible to pay the amounts in this column.	(Out-of-Network) When using nonparticipating providers, you are responsible to pay the amounts in this column.

CONDITIONS AND LIMITATIONS	PARTICIPATING	NONPARTICIPATING
Lifetime Maximum Plan Payment - <i>Per Person</i> <i>In total, the benefit may not exceed the participating maximum</i>	\$2,500,000	\$1,000,000
Maximum Annual Out-Of-Network Payment (per calendar year) ⁶	None	\$500,000
Pre-Existing Conditions (PEC) and Limitations ¹ <i>Waived (entirely or partly) for qualifying pre-existing condition credit</i>	Not covered first 12 months <i>(18 months for late enrollees)</i>	

DEDUCTIBLE AND OUT-OF-POCKET	PARTICIPATING	NONPARTICIPATING
Calendar Year Deductible and Out-of-Pocket Maximum Deductible	\$1,500	\$2,000
Out-of-Pocket Maximum <i>Deductible is included in the Out-of-Pocket Maximum</i>	\$5,000	\$6,500

INPATIENT SERVICES	PARTICIPATING	NONPARTICIPATING
Medical, Surgical, Hospice, and Emergency Admissions <i>Semi-private room, anesthesia, and all related services</i>	20% after deductible	40% after deductible with precert
Maternity and Adoption	Not Covered	Not Covered
Skilled Nursing Facility <i>Up to 60 days/calendar year</i>	20% after deductible	40% after deductible with precert
Rehab Therapy: Physical, Speech, Occupational <i>Up to 40 days/calendar year for all therapy types combined</i>	20% after deductible	40% after deductible with precert

PROFESSIONAL SERVICES	PARTICIPATING	NONPARTICIPATING
Office Visits & Office Surgeries Primary Care Provider (PCP) ¹	\$15 after deductible	40% after deductible (\$15 minimum copay)
Secondary Care Provider (SCP) ¹	\$25 after deductible	40% after deductible (\$25 minimum copay)
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	20%	Not Covered
Diagnostic Tests, Minor ²	Covered 100%	Not Covered
Allergy Tests	See office visits	Not Covered
Allergy Treatment and Serum	20% after deductible	Not Covered
Physician's Fees - <i>Medical, Surgical, Anesthesia</i>	20% after deductible	40% after deductible with precert

OUTPATIENT SERVICES	PARTICIPATING	NONPARTICIPATING
Outpatient Facility and Ambulatory Surgical - <i>Includes all related facility services</i>	20% after deductible	40% after deductible with precert
Ambulance (Air or Ground) - <i>emergencies only</i>	20% after deductible	See Participating Benefit
Emergency Room Participating Facility <i>Includes all facility services rendered in conjunction with the ER</i>	\$100 after deductible	See Participating Benefit
Emergency Room Nonparticipating Facility <i>Includes all facility services rendered in conjunction with the ER</i>	\$200 after deductible	See Participating Benefit
Intermountain InstaCare SM Facilities, Urgent Care Facilities	\$25 after deductible	40% after deductible
Intermountain KidsCare SM Facilities	\$15 after deductible	Not Available
Chemotherapy, Radiation and Dialysis	20% after deductible	40% after deductible
Diagnostic Tests: Minor ²	Covered 100% after deductible	40% after deductible
Diagnostic Tests: Major ²	20% after deductible	40% after deductible with precert
Home Health, Hospice, Outpatient Private Nurse	20% after deductible	40% after deductible with precert
Outpatient Rehab Therapy: Physical, Speech, Occupational <i>Up to 20 visits/calendar year for each therapy type</i>	\$25 after deductible	40% after deductible (\$25 minimum copay)

MISCELLANEOUS SERVICES	PARTICIPATING	NONPARTICIPATING
Chiropractic Care	Not Covered	Not Covered
Durable Medical Equipment (DME) ⁷ <i>Maximum plan payment; up to \$1,500/calendar year</i>	20% after deductible	40% after deductible with precert
Infertility (<i>Select services only</i>) ² <i>Up to \$1,500/calendar year; \$5,000/lifetime</i>	50% after deductible	Not Covered
Injectable drugs and Specialty Medications ⁴	20% after deductible	40% after deductible
Miscellaneous Medical Supplies (MMS)	20% after deductible	40% after deductible
Mental Health and Chemical Dependency		
Inpatient - Up to 10 days/calendar year	50% after deductible	50% after deductible with precert
Outpatient - Up to 25 days/calendar year	50% after deductible	50% after deductible

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PRESCRIPTION DRUGS	
Prescription Drugs ⁴	
Tier 1	\$10 after deductible
Tier 2	25% after deductible
Tier 3	50% after deductible
<i>Up to a 30-day supply for covered medications; generic substitution required</i>	
Maintenance Drug Benefit - 90-Day Supply (Medco by Mail or Retail 90 SM) ⁴	
Tier 1	\$10 after deductible
Tier 2	25% after deductible
Tier 3	50% 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 excluded 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.

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