



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

**CONDITIONS AND LIMITATIONS**

|                                                                                                                                               |                                                                      |             |
|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------|
| Lifetime Maximum Plan Payment - <i>Per Person</i><br><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) <sup>6</sup>                                                                        | None                                                                 | \$500,000   |
| Pre-Existing Conditions (PEC) and Limitations <sup>1</sup><br><i>Waived (entirely or partly) for qualifying pre-existing condition credit</i> | Not covered first 12 months<br><i>(18 months for late enrollees)</i> |             |

**DEDUCTIBLE AND OUT-OF-POCKET**

|                                                                                                                                    | PARTICIPATING | NONPARTICIPATING |
|------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------|
| Calendar Year Deductible and Out-of-Pocket Maximum Deductible<br><i>The entire deductible must be met before benefits are paid</i> | \$3,000       | \$4,000          |
| Out-of-Pocket Maximum<br><i>Deductible is included in the Out-of-Pocket Maximum</i>                                                | \$10,000      | \$14,000         |

**INPATIENT SERVICES**

|                                                                                                                        | PARTICIPATING        | NONPARTICIPATING                  |
|------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------|
| Medical, Surgical, Hospice, and Emergency Admissions<br><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<br><i>Up to 60 days/calendar year</i>                                                         | 20% after deductible | 40% after deductible with precert |
| Rehab Therapy: Physical, Speech, Occupational<br><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<br>Primary Care Provider (PCP) <sup>1</sup> | \$15 after deductible | 40% after deductible<br>(\$15 minimum copay) |
| Secondary Care Provider (SCP) <sup>1</sup>                                   | \$25 after deductible | 40% after deductible<br>(\$25 minimum copay) |
| Preventive Care Office Visits<br>Primary Care Provider (PCP) <sup>1</sup>    | \$15 Copay            | Not Covered                                  |
| Secondary Care Provider (SCP) <sup>1</sup>                                   | \$25 Copay            | Not Covered                                  |
| Adult and Pediatric Immunizations                                            | Covered 100%          | Not Covered                                  |
| Elective Immunizations <sup>2</sup>                                          | 20%                   | Not Covered                                  |
| Diagnostic Tests, Minor <sup>2</sup>                                         | 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<br>with precert         |
| Ambulance (Air or Ground) - <i>emergencies only</i>                                                                    | 20% after deductible          | See Participating Benefit                    |
| Emergency Room Participating Facility<br><i>Includes all facility services rendered in conjunction with the ER</i>     | \$100 after deductible        | See Participating Benefit                    |
| Emergency Room Nonparticipating Facility<br><i>Includes all facility services rendered in conjunction with the ER</i>  | \$200 after deductible        | See Participating Benefit                    |
| Intermountain InstaCare <sup>SM</sup> Facilities, Urgent Care Facilities                                               | \$25 after deductible         | 40% after deductible                         |
| Intermountain KidsCare <sup>SM</sup> Facilities                                                                        | \$15 after deductible         | Not Available                                |
| Chemotherapy, Radiation and Dialysis                                                                                   | 20% after deductible          | 40% after deductible                         |
| Diagnostic Tests: Minor <sup>2</sup>                                                                                   | Covered 100% after deductible | 40% after deductible                         |
| Diagnostic Tests: Major <sup>2</sup>                                                                                   | 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<br><i>Up to 20 visits/calendar year for each therapy type</i> | \$25 after deductible         | 40% after deductible<br>(\$25 minimum copay) |

| MISCELLANEOUS SERVICES                                                                                           | PARTICIPATING        | NONPARTICIPATING                  |
|------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------|
| Chiropractic Care                                                                                                | Not Covered          | Not Covered                       |
| Durable Medical Equipment (DME) <sup>7</sup><br><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> ) <sup>2</sup><br><i>Up to \$1,500/calendar year; \$5,000/lifetime</i> | 50% after deductible | Not Covered                       |
| Injectable drugs and Specialty Medications <sup>4</sup>                                                          | 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              |

5

| PRESCRIPTION DRUGS                                                                                |                       |
|---------------------------------------------------------------------------------------------------|-----------------------|
| Prescription Drugs <sup>4</sup>                                                                   |                       |
| 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 <sup>SM</sup> ) <sup>4</sup> |                       |
| 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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