



PARTICIPATING (In-Network)

You must use participating providers (except emergencies).

CONDITIONS AND LIMITATIONS	
Lifetime Maximum Plan Payment - <i>Per Person</i>	\$2,500,000
Pre-Existing Conditions (PEC) and Limitations ¹ <i>Waived (entirely or partly) for qualifying pre-existing condition credit</i>	Not covered first 12 months
DEDUCTIBLE AND OUT-OF-POCKET	
YOU PAY	
Calendar Year Deductible and Out-of-Pocket Maximum	
Deductible	\$3,000
The entire deductible must be met before benefits are paid	
Out-of-Pocket Maximum	\$10,000
<i>Deductible is included in the Out-of-Pocket Maximum</i>	
INPATIENT SERVICES	
YOU PAY	
Medical, Surgical, Hospice, and Emergency Admissions <i>Semi-private room, anesthesia, and all related services</i>	20% after deductible
Maternity and Adoption	Not covered
Skilled Nursing Facility <i>Up to 60 days/calendar year</i>	20% after deductible
Rehab Therapy: Physical, Speech, Occupational <i>Up to 40 days/calendar year for all therapy types combined</i>	20% after deductible
PROFESSIONAL SERVICES	
YOU PAY	
Office Visits & Office Surgeries	
Primary Care Provider (PCP) ¹	\$15 after deductible
Secondary Care Provider (SCP) ¹	\$25 after deductible
Preventive Care Office Visits	
Primary Care Provider (PCP) ¹	\$15 Copay
Secondary Care Provider (SCP) ¹	\$25 Copay
Adult and Pediatric Immunizations	Covered 100%
Elective Immunizations ²	20%
Diagnostic Tests, Minor ²	Covered 100%
Allergy Tests	See office visits
Allergy Treatment and Serum	20% after deductible
Physician's Fees - <i>Medical, Surgical, Anesthesia</i>	20% after deductible
OUTPATIENT SERVICES	
YOU PAY	
Outpatient Facility and Ambulatory Surgical - <i>Includes all related facility services</i>	20% after deductible
Ambulance (Air or Ground) - <i>emergencies only</i>	20% after deductible
Emergency Room Participating Facility <i>Includes all facility services rendered in conjunction with the ER</i>	\$100 after deductible
Emergency Room Nonparticipating Facility <i>Includes all facility services rendered in conjunction with the ER</i>	\$200 after deductible
Intermountain InstaCare SM Facilities, Urgent Care Facilities	\$25 after deductible
Intermountain KidsCare SM Facilities	\$15 after deductible
Chemotherapy, Radiation and Dialysis	20% after deductible
Diagnostic Tests, Minor ²	Covered 100% after deductible
Diagnostic Tests: Major ²	20% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational <i>Up to 20 visits/calendar year for each therapy type</i>	\$25 after deductible

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

PRESCRIPTION DRUGS	YOU PAY
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. 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.

Benefits are administered and underwritten by SelectHealth.

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