ADMINISTERED BY

PARTICIPATING (IN-NETWORK)

You must use participating providers (except for emergencies).

CONDITIONS and LIMITATIONS	
Lifetime Maximum Plan Payment – Per Person	$1,500,000
Annual Maximum Plan Payment – Per Person[4]	$400,000

MEDICAL DEDUCTIBLE and MEDICAL OUT-OF-POCKET MAXIMUM	You Pay	
Calendar Year Deductible and Out-of-Pocket Maximum Amounts		
Deductible is included in the out-of-pocket maximum	Deductible	Out-of-Pocket Maximum
$500 Deductible	$500	$2,000
$1,000 Deductible	$1,000	$3,000

INPATIENT SERVICES	You Pay
Medical, Surgical, and Hospice	20% after deductible
Maternity *Includes all related maternity services after calendar year deductible. Enroll in the SelectHealth Healthy Beginnings® program: 866-442-5052*	20% after deductible
Skilled Nursing Facility *Up to 30 days/calendar year*	20% after deductible
Rehab Therapy: Physical, Speech, Occupational *Up to 30 days/calendar year for all therapy types combined*	20% after deductible

PROFESSIONAL SERVICES	You Pay
Office Visits and Office Surgeries	
Primary Care Provider (PCP)[2]	20% after deductible
Secondary Care Provider (SCP)[2]	20% after deductible
Preventive Care	
Office Visits	Covered at 100%
Adult and Pediatric Immunizations	Covered at 100%
Diagnostic Tests, Minor	Covered at 100%
Allergy Tests	See Office Visits
Allergy Treatment and Serum	20% after deductible
Physician's Fees – *Medical, Surgical, Anesthesia*	20% after deductible

OUTPATIENT SERVICES	You Pay
Outpatient and Ambulatory Surgical Facility	20% after deductible
Ambulance (Air) – *emergencies only*	20% after deductible
Ambulance – *emergencies and urgent conditions only*	20% after deductible
Emergency Room Participating Facility	20% after deductible
Emergency Room Nonparticipating Facility	20% after deductible
Intermountain InstaCare℠ Facilities, Urgent Care Facilities	20% after deductible
Intermountain KidsCare℠ Facilities	20% after deductible
Intermountain ExpressCare℠ Facilities	20% after deductible
Chemotherapy, Radiation, and Dialysis	20% after deductible
Diagnostic Tests, Minor	20% after deductible
Diagnostic Tests, Major[1]	20% after deductible
Home Health, Hospice	20% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational *Up to 20 visits/calendar year for each therapy type*	20% after deductible

See next page for additional benefits and footnotes.

MISCELLANEOUS SERVICES	You Pay
Chiropractic Care	Not covered
Durable Medical Equipment (DME)[3]	20% after deductible
Infertility	Not covered
Injectable Drugs and Specialty Medications[3,4]	20% after deductible
Mental Health and Chemical Dependency[3]	
Inpatient – Up to 10 days/calendar year	20% after deductible
Outpatient – Up to 20 visits/calendar year	20% after deductible
Miscellaneous Medical Supplies	20% after deductible
Cochlear Implants – *Unilateral Only*	20% after deductible
Donor Fees for Covered Organ Transplants – *Up to $40,000/transplant*	20% after deductible

PRESCRIPTION DRUGS[3]	You Pay
Prescription Drug List (formulary)	RxSelect℠

If your medical deductible is:
Your Rx deductible per person/calendar year is:
Your Rx out-of-pocket maximum per person/calendar year is:
The Rx Deductible is included in the Rx out-of-pocket maximum

Medical Deductible	$500	$1,000
Rx Deductible	$150	$250
Rx Out of Pocket	$3,950	$2,950

Rx Copay and Coinsurance	
Up to a 30-day supply for covered medications; generic substitution required	
Tier 1	$5 after Rx deductible
Tier 2	25% after Rx deductible
Tier 3	50% after Rx deductible
Maintenance Drug Benefit	
90-Day Supply (The Medco Pharmacy™ or Retail90℠); generic substitution required	
Tier 1	$5 after Rx deductible
Tier 2	25% after Rx deductible
Tier 3	50% after Rx deductible

FOOTNOTES

1. Refer to the Enrollee Agreement for more information.
2. Refer to your HIPUtah Provider & Facility Directory to identify whether a provider is a Primary Care or Secondary Care Provider.
3. Preauthorization is required on the following services: (a) certain injectable drugs and specialty medications; (b) certain prescription drugs; (c) certain DME items; (d) certain mental health and chemical dependency services; and (e) all services obtained outside the United States unless for a routine, urgent, or emergent condition. Benefits may be reduced or denied if you do not preauthorize certain services. Please refer to your Enrollee Agreement or call Member Services for more information
4. Injectable drugs are not covered after $300,000 of the total annual maximum plan payment has been met.

All deductible/copay/coinsurance amounts are based on allowed 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 maximum. Refer to your Enrollee Agreement or Provider & Facility Directory for more information.

MEMBER PAYMENT SUMMARY – Federal-HIPUtah (COMBO HDHP) 01/01/12

ADMINISTERED BY

	PARTICIPATING (IN-NETWORK)	
	You must use participating providers (except for emergencies).	
CONDITIONS and LIMITATIONS		
Lifetime Maximum Plan Payment – Per Person	$1,500,000	
Annual Maximum Plan Payment – Per Person[4]	$400,000	
DEDUCTIBLE and OUT-OF-POCKET MAXIMUM	**$2,500 Deductible**	**$5,000 Deductible**
Calendar Year Deductible and Out-of-Pocket Maximum Amounts		
Deductible is included in the out-of-pocket maximum		
Deductible	$2,500	$5,000
Out-of-Pocket Maximum	$4,000	$5,000
INPATIENT SERVICES	**$2,500 Deductible**	**$5,000 Deductible**
Medical, Surgical, and Hospice	20% after deductible	100% after deductible
Maternity *Includes all related maternity services after calendar year deductible. Enroll in the SelectHealth Healthy Beginnings® program: 866-442-5052*	20% after deductible	100% after deductible
Skilled Nursing Facility *Up to 30 days/calendar year*	20% after deductible	100% after deductible
Rehab Therapy: Physical, Speech, Occupational *Up to 30 days/calendar year for all therapy types combined*	20% after deductible	100% after deductible
PROFESSIONAL SERVICES	**$2,500 Deductible**	**$5,000 Deductible**
Office Visits and Office Surgeries		
Primary Care Provider (PCP)[2]	20% after deductible	100% after deductible
Secondary Care Provider (SCP)[2]	20% after deductible	100% after deductible
Preventive Care		
Office Visits	Covered at 100%	Covered at 100%
Adult and Pediatric Immunizations	Covered at 100%	Covered at 100%
Diagnostic Tests, Minor	Covered at 100%	Covered at 100%
Allergy Tests	See Office Visits	See Office Visits
Allergy Treatment and Serum	20% after deductible	100% after deductible
Physician's Fees – *Medical, Surgical, Anesthesia*	20% after deductible	100% after deductible
OUTPATIENT SERVICES	**$2,500 Deductible**	**$5,000 Deductible**
Outpatient and Ambulatory Surgical Facility	20% after deductible	100% after deductible
Ambulance (Air) – *emergencies only*	20% after deductible	100% after deductible
Ambulance – *emergencies and urgent conditions only*	20% after deductible	100% after deductible
Emergency Room Participating Facility	20% after deductible	100% after deductible
Emergency Room Nonparticipating Facility	20% after deductible	100% after deductible
Intermountain InstaCare℠ Facilities, Urgent Care Facilities	20% after deductible	100% after deductible
Intermountain KidsCare℠ Facilities	20% after deductible	100% after deductible
Intermountain ExpressCare℠ Facilities	20% after deductible	100% after deductible
Chemotherapy, Radiation, and Dialysis	20% after deductible	100% after deductible
Diagnostic Tests, Minor	20% after deductible	100% after deductible
Diagnostic Tests, Major[1]	20% after deductible	100% after deductible
Home Health, Hospice	20% after deductible	100% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational *Up to 20 visits/calendar year for each therapy type*	20% after deductible	100% after deductible

See next page for additional benefits and footnotes.

MISCELLANEOUS SERVICES	$2,500 Deductible	$5,000 Deductible
Chiropractic Care	Not covered	Not covered
Durable Medical Equipment (DME)[3]	20% after deductible	100% after deductible
Infertility	Not covered	Not covered
Injectable Drugs and Specialty Medications[3,4]	20% after deductible	100% after deductible
Mental Health and Chemical Dependency[3]		
Inpatient – Up to 10 days/calendar year	20% after deductible	100% after deductible
Outpatient – Up to 20 visits/calendar year	20% after deductible	100% after deductible
Miscellaneous Medical Supplies	20% after deductible	100% after deductible
Cochlear Implants – *Unilateral Only*	20% after deductible	100% after deductible
Donor Fees for Covered Organ Transplants – *Up to $40,000/transplant*	20% after deductible	100% after deductible

PRESCRIPTION DRUGS[3]	$2,500 Deductible	$5,000 Deductible
Prescription Drug List (formulary)	RxSelect℠	RxSelect℠
Rx Copay and Coinsurance		
Up to a 30-day supply for covered medications; generic substitution required		
Tier 1	$5 after deductible	100% after deductible
Tier 2	25% after deductible	100% after deductible
Tier 3	50% after deductible	100% after deductible
Maintenance Drug Benefit		
90-Day Supply (The Medco Pharmacy™ or Retail90℠); generic substitution required		
Tier 1	$5 after deductible	100% after deductible
Tier 2	25% after deductible	100% after deductible
Tier 3	50% after deductible	100% after deductible

FOOTNOTES

1. Refer to the Enrollee Agreement for more information.
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