



ADMINISTERED BY  
**selecthealth.**

**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 <sup>4</sup>	\$400,000

**MEDICAL DEDUCTIBLE and MEDICAL OUT-OF-POCKET MAXIMUM****You Pay**

Calendar Year Deductible and Out-of-Pocket Maximum Amounts <i>Deductible is included in the out-of-pocket maximum</i>	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 <i>Includes all related maternity services after calendar year deductible. Enroll in the SelectHealth Healthy Beginnings® program: 866-442-5052</i>	20% after deductible
Skilled Nursing Facility <i>Up to 30 days/calendar year</i>	20% after deductible
Rehab Therapy: Physical, Speech, Occupational <i>Up to 30 days/calendar year for all therapy types combined</i>	20% after deductible

**PROFESSIONAL SERVICES****You Pay**

Office Visits and Office Surgeries	
Primary Care Provider (PCP) <sup>2</sup>	20% after deductible
Secondary Care Provider (SCP) <sup>2</sup>	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 <sup>SM</sup> Facilities, Urgent Care Facilities	20% after deductible
Intermountain KidsCare <sup>SM</sup> Facilities	20% after deductible
Intermountain ExpressCare <sup>SM</sup> Facilities	20% after deductible
Chemotherapy, Radiation, and Dialysis	20% after deductible
Diagnostic Tests, Minor	20% after deductible
Diagnostic Tests, Major <sup>1</sup>	20% after deductible
Home Health, Hospice	20% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational <i>Up to 20 visits/calendar year for each therapy type</i>	20% after deductible

**MISCELLANEOUS SERVICES****You Pay**

Chiropractic Care	Not covered
Durable Medical Equipment (DME) <sup>3</sup>	20% after deductible
Infertility	Not covered
Injectable Drugs and Specialty Medications <sup>3,4</sup>	20% after deductible
Mental Health and Chemical Dependency <sup>3</sup> <i>Inpatient - Up to 10 days/calendar year</i> <i>Outpatient - Up to 20 visits/calendar year</i>	20% after deductible 20% after deductible
Miscellaneous Medical Supplies	20% after deductible
Cochlear Implants - <i>Unilateral Only</i>	20% after deductible
Donor Fees for Covered Organ Transplants - <i>Up to \$40,000/transplant</i>	20% after deductible

**PRESCRIPTION DRUGS<sup>2</sup>****You Pay**

Prescription Drug List (formulary)	RxSelect <sup>SM</sup>
If your medical deductible is: Your Rx deductible per person/calendar year is:	<u>\$500</u> <u>\$1,000</u> \$150   \$250
<i>The Rx Deductible does not apply to medical out-of-pocket amounts</i>	
Rx Copay and Coinsurance - <i>Up to a 30-day supply for covered medications; generic substitution required</i>	
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 <sup>TM</sup> or Retail90 <sup>SM</sup> ); <i>generic substitution required</i>	
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.*



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## CONDITIONS and LIMITATIONS

Lifetime Maximum Plan Payment - Per Person	\$1,500,000
Annual Maximum Plan Payment - Per Person <sup>4</sup>	\$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<sup>SM</sup> 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

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Preventive Care

Office Visits

Covered at 100%

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Adult and Pediatric Immunizations

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Diagnostic Tests, Minor

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## OUTPATIENT SERVICES

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\$5,000 Deductible

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20% after deductible

100% after deductible

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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<sup>SM</sup> Facilities, Urgent Care Facilities

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20% after deductible

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Diagnostic Tests, Minor

20% after deductible

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20% after deductible

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Home Health, Hospice

20% after deductible

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Outpatient Rehab Therapy: Physical, Speech, Occupational

*Up to 20 visits/calendar year for each therapy type*

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PRESCRIPTION DRUGS <sup>2</sup>	\$2,500 Deductible	\$5,000 Deductible
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