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	SCHEDULE OF BENEFITS	
	PARTICIPATING *(In-Network)* When using participating providers, you are responsible to pay the amounts in this column.	**NONPARTICIPATING** *(Out-of-Network)* When using nonparticipating providers, you are responsible to pay the amounts in this column.
CONDITIONS AND LIMITATIONS		
Lifetime Maximum Plan Payment - *Per Person*	None	
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	Plan year	
Maximum Annual Out-of-Network Payment - (per plan year)	None	None
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET	**PARTICIPATING**	**NONPARTICIPATING**
Deductible - Per Person/Family (per plan year)	$500/$1000	$1000/$2000
Total Out-of-Pocket Maximum - Per Person/Family (per plan year)	$3500/$7000	$5000/$10000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Medical and Surgical [4]	20% after deductible	30% after deductible
Hospice [4]	20% after deductible	30% after deductible
Skilled Nursing Facility [4] - Up to 60 days per plan year	20% after deductible	30% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational [4]	20% after deductible	30% after deductible
Up to 40 days per plan year for all therapy types combined		
PROFESSIONAL SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP) [1]	$25 after deductible	30% after deductible
Secondary Care Provider (SCP) [1]	$35 after deductible	30% after deductible
Salt Lake County HealthyMe Medical Clinic	$10	Not Covered
Allergy Tests	See Office Visits Above	30% after deductible
Allergy Treatment and Serum	20% after deductible	30% after deductible
Major Office Surgery *(Surgical and Endoscopic Services Over $350)*	20% after deductible	30% after deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after deductible	30% after deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA [2,3]	**PARTICIPATING**	**NONPARTICIPATING**
Primary Care Provider (PCP) [1]	Covered 100%	Not Covered
Secondary Care Provider (SCP) [1]	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Not Covered
OUTPATIENT SERVICES [4]	**PARTICIPATING**	**NONPARTICIPATING**
Outpatient Facility and Ambulatory Surgical	20% after deductible	30% after deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after deductible	See Participating Benefit
Emergency Room - *(Participating facility)*	$150 after deductible	See Participating Benefit
Emergency Room - *(Nonparticipating facility)*	$150 after deductible	See Participating Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$45 after deductible	30% after deductible
Intermountain KidsCare® Facilities	$25 after deductible	30% after deductible
Chemotherapy, Radiation and Dialysis	20% after deductible	30% after deductible
Diagnostic Tests: Minor [2]	Covered 100% after deductible	30% after deductible
Diagnostic Tests: Major [2]	20% after deductible	30% after deductible
Home Health, Hospice, Outpatient Private Nurse [4]	Covered 100% after deductible	30% after deductible
Up to 60 visits per plan year		
Outpatient Rehab Therapy: Physical, Speech, Occupational	$35 after deductible	30% after deductible
Up to 20 visits per plan year for each therapy type		

See other side for additional benefits

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	SCHEDULE OF BENEFITS	
	PARTICIPATING *(In-Network)*	**NONPARTICIPATING** *(Out-of-Network)*
MISCELLANEOUS SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Durable Medical Equipment (DME) [4]	20% after deductible	30% after deductible
Miscellaneous Medical Supplies (MMS) [3]	20% after deductible	30% after deductible
Maternity [4]	See Professional, Inpatient or Outpatient	30% after deductible
Cochlear Implants [4]	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services*	*50% after deductible	*50% after deductible
Donor Fees for Covered Organ Transplants [4]	20% after deductible	Not Covered
TMJ (Temporomandibular Joint) Services - *Up to $1,000 lifetime*	50% after deductible	50% after deductible
Blepharoplasty	50% after deductible	50% after deductible
Breast Reduction	20% after deductible	30% after deductible
Chiropractic	$35 after deductible *(Up to 10 visits per plan year)*	
OTHER BENEFITS	**PARTICIPATING**	**NONPARTICIPATING**
Mental Health and Chemical Dependency [4]		
Mental Health Office Visits	$35 after deductible	Not Covered
Inpatient	20% after deductible	Not Covered [4]
Outpatient	20% after deductible	Not Covered [4]
Residential Treatment [2]	Not Covered	Not Covered [4]
Autism - *Up to $36,000/year ages 0-9; Up to $15,000/year ages 10-18*	20% after deductible	Not Covered
Limited to 150 visits/year for all therapy types combined		
Adoption [4]	Covered 100% up to $4,000	
Injectable Drugs and Specialty Medications [4]	20% after deductible	30% after deductible
PRESCRIPTION DRUGS		
Prescription Drug List (formulary)	RxSelect®	
Prescription Drugs - *Up to 30 Day Supply of Covered Medications* [4]		
Tier 1	$10	
Tier 2	25% with a minimum of $25 and maximum of $75 after participating deductible	
Tier 3	50% with a minimum of $50 and maximum of $100 after participating deductible	
Tier 4	20% with a maximum of $150 after participating deductible	
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90®)-selected drugs* [4]		
Tier 1	$20	
Tier 2	25% with a minimum of $50 and maximum of $150 after participating deductible	
Tier 3	50% with a minimum of $100 and maximum of $200 after participating deductible	
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic	

To remain compliant with state and federal regulations including the Affordable Care Act (ACA), these benefits are subject to change.

1 Refer to **selecthealth.org/findadoctor** to identify whether a provider is a primary or secondary care provider.

2 Refer to your Summary Plan Description for more information.

3 Frequency and/or quantity limitations apply to some preventive care and MMS services.

4 Preauthorization is required for the following: (a) all inpatient services; (b) certain injectable drugs and specialty medications; (c) certain prescription drugs; (d) certain DME items and prosthetic items; (e) certain mental health and chemical dependency services; (f) maternity stays longer than two days for normal delivery or longer than four days for cesarean; (g) home health nursing; (h) pain management/pain clinic services; (i) outpatient private nurse; (j) organ transplants; (k) cochlear implants and (l) certain genetic tests. Benefits may be reduced or denied if you do not preauthorize certain services. Please refer to Section 11-- "Healthcare Management", in your Summary Plan Description, for details.

* Not applied to Medical out-of-pocket maximum.

All covered services obtained outside the United States, except for routine, urgent, or emergency conditions require preauthorization.

All deductible/copay/coinsurance amounts are based on the allowed amounts and not on the provider's billed charges. You are responsible to pay for excess charges on covered services obtained from non-participating providers and facilities. Excess charges are not applied to the medical out-of-pocket maximums.
For more information, call Member Services at 800-538-5038 weekdays, from 7:00 a.m.to 8:00 p.m., and Saturdays from 9:00 a.m. to 2:00 p.m.

Select Med Plus participating and nonparticipating benefits are administered by SelectHealth.