INDIVIDUAL MEMBER PAYMENT SUMMARY (MPS) 1/1/2017 I30A0914

This is a Bronze plan as defined by the Affordable Care Act

select:med PREFERENCE

	PARTICIPATING
	In-Network You must use participating providers (except for emergencies)
DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM[4]	**PARTICIPATING**
Self Only Coverage, 1 person enrolled - per calendar year	
Deductible	$6,350
Out-of-Pocket Maximum	$7,150
Family Coverage, 2 or more enrolled - per calendar year	
Deductible - per person/family	$6,350/$12,700
Out-of-Pocket Maximum - per person/family	$7,150/$14,300
This amount is your deductible + your coinsurance and copay (medical and Rx)	
INPATIENT SERVICES[3]	**PARTICIPATING**
Medical, Surgical, Hospice, Emergency Admissions	30% after deductible
Skilled Nursing Facility	30% after deductible
Up to 60 days/calendar year	
Rehab Therapy: Physical, Speech, Occupational	30% after deductible
Up to 40 days/calendar year for all therapy types combined	
PROFESSIONAL SERVICES[3]	**PARTICIPATING**
Office Visits and Office Surgeries	
Primary Care Provider (PCP)[1]	$50 after deductible
Deductible waived for the first 3 PCP and Mental Health office visits combined per year	
Secondary Care Provider (SCP)[1]	$65 after deductible
Allergy Tests	See office visits
Allergy Treatment and Serum	30% after deductible
Physician's Fees – *Medical, Surgical, Anesthesia*	30% after deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2]	**PARTICIPATING**
Office Visits (PCP/SCP)[1]	Covered 100%
Adult and Pediatric Immunizations	Covered 100%
Diagnostic Tests: Minor	Covered 100%
Other Preventive Services	Covered 100%
VISION SERVICES	**PARTICIPATING**
Pediatric Preventive Eye Exams - Through Age 18 Years, Only[2]	Covered 100%
Adult Preventive Eye Exams - Age 19 and Over[2]	Covered 100%
All Other Eye Exams - Adult/Pediatric	$65 after deductible
Contacts and Corrective Lenses - Through Age 18 Years, Only	30% after deductible
Limit one pair of eyeglass lenses or contact lenses per year	
OUTPATIENT SERVICES	**PARTICIPATING**
Outpatient Facility and Ambulatory Surgical	30% after deductible
Ambulance (Air or Ground) – *emergencies only*	30% after deductible
Emergency Room Participating Facility	$600 after deductible
Emergency Room Nonparticipating Facility	$600 after deductible
Intermountain InstaCare® Facilities, Urgent Care Facilities	$65 after deductible
Intermountain KidsCare® Facilities, Intermountain Connect Care®	$50 after deductible
Chemotherapy, Radiation, Dialysis	30% after deductible
Diagnostic Tests: Minor	Covered 100% after deductible
Diagnostic Tests: Major	30% after deductible
Home Health[3]	30% after deductible
Hospice[3]	30% after deductible
Outpatient Private Nurse[3]	30% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational	$65 after deductible
Up to 20 visits/calendar year for all therapy types combined	
Outpatient Habilitative Therapy: Physical, Speech, Occupational	$65 after deductible
Up to 20 visits/calendar year for all therapy types combined	

See next page for additional benefits and footnotes.

MISCELLANEOUS SERVICES	PARTICIPATING
Maternity and Adoption[3,5]	See Professional, Inpatient, or Outpatient Services
Includes all related maternity and adoption services. Enroll in SelectHealth Healthy Beginnings Program® : 866-442-5052	
Chiropractic Care	Not Covered
Miscellaneous Medical Supplies (MMS)[2]	30% after deductible
Durable Medical Equipment (DME)[3]	30% after deductible
Prosthetic Devices[3]	30% after deductible
Injectable Drugs and Specialty Medications[3]	40% after deductible
Infertility (s*elect services only)*	50% after deductible
Maximum plan payment: up to $1,500/calendar year; $5,000/lifetime	
Pediatric Dental, SelectHealth Classic Network *(through 18 years)*	$65
Oral examinations and cleanings - two per calendar year	
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Applied behavior analysis and behavioral health services up to $30,000 or 600 hours/calendar year, whichever is greater	
Mental Health and Chemical Dependency[3]	
Office Visits	$50 after deductible
Deductible waived for the first 3 PCP and Mental Health office visits combined per year	
Inpatient	30% after deductible
Outpatient	30% after deductible
Residential Treatment Center	30% after deductible
Cochlear Implants[3]	See Professional, Inpatient, or Outpatient Services
Donor Fees for Organ Transplants[3]	See Professional, Inpatient, or Outpatient Services
TMJ (Temporomandibular Joint) Services	Not Covered

PRESCRIPTION DRUGS[3]	PARTICIPATING
Prescription Drug List (formulary)	RxCore®
Prescription Drug Deductible - *Per Person*	$1,000
Out-of-Pocket Maximum	Combined with medical
Copay – *Up to a 30-day supply for covered medications; generic substitution required.*	
Tier 1	$20
Tier 2	30% after pharmacy deductible
Tier 3	50% after pharmacy deductible
Tier 4	40% after pharmacy deductible
Maintenance Drug *generic substitution required.*	
Tier 1 - *90-day supply (Mail-Order, Retail90®)*	$20
Tier 2 - *Up to a 30-day supply for covered medications*	30% after pharmacy deductible
Tier 3 - *Up to a 30-day supply for covered medications*	50% after pharmacy deductible

FOOTNOTES

1. Visit **selecthealth.org/findadoctor** to find out whether a provider is a Primary Care or Secondary Care Provider.

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

3. Preauthorization is required for the following: all inpatient services; certain injectable drugs and specialty medications; certain prescription drugs; certain DME items and prosthetic items; certain mental health and chemical dependency services; maternity stays longer than two days for normal delivery or longer than four days for cesarean and all deliveries outside of the service area; home health nursing; pain management/pain clinic services; outpatient private nurse; organ transplants; cochlear implants and 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 Certificate of Coverage, for details.

4. All deductible/copay/coinsurance amounts are based on the allowed amounts and not on the providers billed charges. Nonparticipating Providers or Facilities have not agreed to accept the allowed amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services, sometimes referred to as balance billing. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

5. SelectHealth provides a $4,000 adoption indemnity benefit as outlined by the state of Utah. Deductible, copay, or coinsurance listed under the maternity benefit applies and may exhaust the benefits prior to any plan payment.

For more information, refer to your Certificate of Coverage or Contract or 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. TTY users should call 711.