selecthealth SIGNATURE

	MEMBER PAYMENT SUMMARY	
	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		
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[5]	**PARTICIPATING**	**NONPARTICIPATING**
Self Only Coverage, 1 person enrolled - per plan year		
Deductible	$1,000	$2,000
Out-of-Pocket Maximum	$3,500	$6,000
Family Coverage, 2 or more enrolled - per plan year		
Deductible - per person/family	$1000/$3000	$2000/$6000
Out-of-Pocket Maximum - per person/family	$3500/$7000	$6000/$12000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Medical, Surgical and Hospice[4]	15% after deductible	30% after deductible
Skilled Nursing Facility[4] - Up to 60 days per plan year	15% after deductible	30% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	15% 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]	$35	30% after deductible
Secondary Care Provider (SCP)[1]	$50	30% after deductible
Allergy Tests	See Office Visits Above	50% after deductible
Allergy Treatment and Serum	15%	50% after deductible
Major Surgery	15%	30% after deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	15% after deductible	30% after deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**PARTICIPATING**	**NONPARTICIPATING**
Primary Care Provider (PCP)[1]	Covered 100%	50% after deductible
Secondary Care Provider (SCP)[1]	Covered 100%	50% after deductible
Adult and Pediatric Immunizations	Covered 100%	50% after deductible
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	50% after deductible
Diagnostic Tests: Minor	Covered 100%	50% after deductible
Other Preventive Services	Covered 100%	50% after deductible
VISION SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Preventive Eye Exams	Covered 100%	50% after deductible
All Other Eye Exams	$50	30% after deductible
OUTPATIENT SERVICES[4]	**PARTICIPATING**	**NONPARTICIPATING**
Outpatient Facility and Ambulatory Surgical	$100 after deductible	30% after deductible
Ambulance (Air or Ground) - *Emergencies Only*	15% after deductible	See Participating Benefit
Emergency Room - *(Participating facility)*	$200 after deductible	See Participating Benefit
Emergency Room - *(Nonparticipating facility)*	$200 after deductible	See Participating Benefit
Urgent Care Facilities	$35	30% after deductible
Chemotherapy, Radiation and Dialysis	15% after deductible	30% after deductible
Diagnostic Tests: Minor[2]	Covered 100%	30% after deductible
Diagnostic Tests: Major[2]	$50 after deductible	30% after deductible
Home Health, Hospice, Outpatient Private Nurse	15% after deductible	30% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational	$50 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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	MEMBER PAYMENT SUMMARY	
	PARTICIPATING *(In-Network)*	**NONPARTICIPATING** *(Out-of-Network)*
MISCELLANEOUS SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Durable Medical Equipment (DME)[4]	15% after deductible	30% after deductible
Miscellaneous Medical Supplies (MMS)[3]	15% after deductible	30% after deductible
Maternity[4]	See Professional, Inpatient or Outpatient	30% after deductible
Cochlear Implants[4]	See Professional, Inpatient or Outpatient	50% after deductible
Infertility - *Select Services* *(Max Plan Payment $1,500/ plan year; $5,000 lifetime)*	*50% after deductible	*50% after deductible
Donor Fees for Covered Organ Transplants	15% after deductible	50% after deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	50% after deductible
OPTIONAL BENEFITS	**PARTICIPATING**	**NONPARTICIPATING**
Mental Health and Chemical Dependency[4]		
Office Visits	$35	30% after deductible
Inpatient	15% after deductible	30% after deductible
Outpatient	15%	30% after deductible
Residential Treatment[2]	15%	30% after deductible
Chiropractic	*$25 (up to 15 visits per plan year)	*50% after deductible
Injectable Drugs and Specialty Medications[4]	15% after deductible	30% after deductible
PRESCRIPTION DRUGS		
Pharmacy Deductible - Per Person per plan year	$100	
Prescription Drug List (formulary)	RxSelect®	
Prescription Drugs - *Up to 30 Day Supply of Covered Medications*[4]		
Tier 1	$15	
Tier 2	$30 after pharmacy deductible	
Tier 3	$50 after pharmacy deductible	
Tier 4	$100 after pharmacy deductible	
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90®)-selected drugs*[4]		
Tier 1	$15	
Tier 2	$60 after pharmacy deductible	
Tier 3	$150 after pharmacy 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 Certificate of Coverage for more information.

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

4 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.

5 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. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

* 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.

To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.

Benefits are administered and underwritten by SelectHealth.