

Med Plus Gold 750 Medical Deductible

This is a Gold plan as defined by the Affordable Care Act.



MED NETWORK

	IN-NETWORK	OUT-OF-NETWORK
	When using In-Network Providers, you are responsible to pay the amounts in this column.	When using Out-of-Network Providers, you are responsible to pay the amounts in this column.
DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM^{4,5}	IN-NETWORK	OUT-OF-NETWORK
Self Only Coverage, 1 person enrolled - per calendar Year		
Deductible	\$750	\$3,000
Out-of-Pocket Maximum	\$8,950	\$20,000
Family Coverage, 2 or more enrolled - per calendar Year		
Deductible - per person/family	\$750/\$2,250	\$3,000/\$9,000
Out-of-Pocket Maximum - per person/family	\$8,950/\$17,900	\$20,000/\$40,000
<i>This amount is your Deductible + your Coinsurance and Copay (medical and Rx)</i>		
<i>The deductible only applies on lines where "after deductible" is noted</i>		
INPATIENT SERVICES³	IN-NETWORK	OUT-OF-NETWORK
Medical, Surgical, Hospice, Emergency Admissions	20% after Deductible	50% after Deductible
Hospital Level Care at Home	20% after Deductible	Not Covered
Skilled Nursing Facility	20% after Deductible	50% after Deductible
<i>Up to 60 days/calendar Year</i>		
Rehab Therapy: Physical, Speech, Occupational	\$50 after Deductible	50% after Deductible
<i>Up to 40 days/calendar Year for all therapy types combined</i>		
Physician's Fees - Medical, Surgical, Maternity, Anesthesia	20% after Deductible	50% after Deductible
PROFESSIONAL SERVICES³	IN-NETWORK	OUT-OF-NETWORK
Office Visits and Office Surgeries		
Primary Care Provider (PCP) ¹	\$25	50% after Deductible
Primary Care Provider (PCP) Virtual Visits ¹	Covered 100%	Not Covered
Specialist/Secondary Care Provider (SCP) ¹	\$50	50% after Deductible
Allergy Tests	See office visits	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Physician's Fees - Surgical	20% after Deductible	50% after Deductible
Physician's Fees - Medical, Maternity, Anesthesia	20% after Deductible	50% after Deductible
PREVENTIVE CARE AS OUTLINED BY THE ACA²	IN-NETWORK	OUT-OF-NETWORK
Office Visits (PCP/SCP) ¹	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Not Covered
VISION SERVICES	IN-NETWORK	OUT-OF-NETWORK
Pediatric Preventive Eye Exams - Through Age 18 Years, Only ²	Covered 100%	Not Covered
Adult Preventive Eye Exams - Age 19 and Over ²	Covered 100%	Not Covered
All Other Eye Exams - Adult/Pediatric	\$50	50% after Deductible
Contacts and Corrective Lenses - Through Age 18 Years, Only	20% after Deductible	50% after Deductible
<i>Limit one pair of eyeglass lenses or contact lenses per Year</i>		
OUTPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
Outpatient Facility	20% after Deductible	50% after Deductible
Ambulatory Surgical Center	10% after Deductible	50% after Deductible
Imaging Center	\$70 after Deductible	50% after Deductible
Ambulance (Air or Ground) - emergencies only	20% after Deductible	See In-Network Benefit
Emergency Room	\$350 after Deductible	See In-Network Benefit
Intermountain InstaCare [®] Facilities, Urgent Care Facilities	\$50	50% after Deductible
Intermountain KidsCare [®] Facilities	\$25	Not Available
Intermountain Connect Care [®]	Covered 100%	Not Available
Radiation	20% after Deductible	50% after Deductible
Dialysis	20% after Deductible	50% after Deductible
Diagnostic Tests: Laboratory, per Provider	Covered 100%	50% after Deductible
Diagnostic Tests: Xrays and Minor, per Provider	Covered 100%	50% after Deductible
Diagnostic Tests: Major, per Provider	20% after Deductible	50% after Deductible
Home Health ³	20% after Deductible	50% after Deductible
Hospice ³	20% after Deductible	50% after Deductible
Outpatient Cardiac Rehab	Covered 100%	50% after Deductible
Outpatient Private Nurse ³	20% after Deductible	50% after Deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational	\$25	50% after Deductible
<i>Up to 20 visits/calendar Year for all therapy types combined</i>		
Outpatient Habilitative Therapy: Physical, Speech, Occupational	\$35	50% after Deductible
<i>Up to 20 visits/calendar Year for all therapy types combined</i>		

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MISCELLANEOUS SERVICES	IN-NETWORK	OUT-OF-NETWORK
Maternity and Adoption ^{3,6} <i>Includes all related maternity and adoption services. Enroll in Select Health Healthy Beginnings Program[®] : 866-442-5052</i>	See Professional, Inpatient, or Outpatient Services	See Professional, Inpatient, or Outpatient Services
Chiropractic Care <i>Up to 10 visits/calendar Year</i>	\$20	50% after Deductible
Miscellaneous Medical Supplies (MMS) ²	20% after Deductible	50% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Substance Use Disorder Services	See Professional, Inpatient, Outpatient, or Mental Health and Substance Use Disorder Services
Durable Medical Equipment (DME) ³	20% after Deductible	50% after Deductible
Prosthetic Devices ³	20% after Deductible	50% after Deductible
Healthcare Provider Administered Injectable or Infusible Drugs ³	50% after Deductible	50% after Deductible
Chemotherapy ³	50% after Deductible	50% after Deductible
Diabetes Education	20% after Deductible	50% after Deductible
Infertility (<i>select services only</i>)	50% after Deductible	Not Covered
Pediatric Dental, Select Health Classic Network (<i>through 18 Years</i>) <i>Oral examinations and cleanings - two per calendar Year</i>	\$50	Not Covered
Mental Health and Substance Use Disorder ³		
Office Visits	\$25	50% after Deductible
Virtual Visits	Covered 100%	50% after Deductible
Inpatient	20% after Deductible	50% after Deductible
Outpatient	20% after Deductible	50% after Deductible
Residential Treatment Center	20% after Deductible	50% after Deductible
Cochlear Implants or Auditory Osseointegrated Devices ³ <i>One device every 36 months per ear</i>	See Professional, Inpatient, or Outpatient Services	Not Covered
TMJ (Temporomandibular Joint) Services <i>Up to \$2,000/lifetime</i>	See Professional, Inpatient, or Outpatient Services	Not Covered
PRESCRIPTION DRUGS³		
Prescription Drug List (formulary)		RxCore [®] Individual/Family \$250/\$750 Combined with medical
Prescription Drug Deductible		
Out-of-Pocket Maximum		
Prescription Drugs – <i>Up to 30-day supply for covered medications</i>		
Tier 1		\$5
Tier 2		\$30
Tier 3		25% after pharmacy Deductible
Tier 4		50% after pharmacy Deductible
Tier 5		50% after pharmacy Deductible
Maintenance Drugs – <i>90-day supply (Mail-Order, Retail90[®])</i>		
Tier 1		\$5
Tier 2		\$30
Tier 3		25% after pharmacy Deductible
Tier 4		50% after pharmacy Deductible
Generic Substitution Required		Generic required or must pay Copay plus cost difference between name brand and generic

FOOTNOTES

1. Visit selecthealth.org/find-care to find out whether a Provider is a Primary Care or Secondary Care Provider.
2. Frequency and/or quantity limitations apply to some preventive and MMS services.
3. Preauthorization is required for certain services. Benefits may be reduced or denied if you do not preauthorize certain services with Out-of-Network Providers. 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 Amount and not on billed charges. Out-of-Network Providers or Facilities may not accept the Allowed Amount for Covered Services. When this occurs, you may be responsible for Excess Charges.
5. Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.
6. Select Health 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.
7. Select Health will cover an insulin from each therapeutic category with a cap of \$10 per prescription of a 30-day supply.

If a member is within 40 miles of an in-network urgent care provider and receives services from an out of network urgent care provider, the claim will process as out of network and the member may be balance billed. Emergency care is covered as in-network regardless of location.

All Covered Services obtained outside the United States, except for routine, Urgent, or Emergency conditions require preauthorization.

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.

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.



Network: PDP Plus

	In-Network ¹ % of Negotiated Fee ²	Out-of-Network ¹ % of R&C Fee ^{**}
Coverage Type		
Type A: Preventive (cleanings, exams)	100%	100%
Type B: Basic Restorative (fillings, extractions)	80%	80%
Type C: Major Restorative (bridges, dentures, extractions)	50%	50%
Type D: Orthodontia	50%	50%
Deductible[†]		
Individual	\$50	\$50
Family	\$150	\$150
Annual Maximum Benefit		
Per Person	\$1,750	\$1,750
Orthodontia Lifetime Maximum		
Per Person ^{***}	\$1,500	\$1,500

Child(ren)'s eligibility for dental coverage is from birth up to age 26.

¹"In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.

²Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.

^{**}R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

[†]Applies only to Type B & C Services.

^{***} Orthodontia included for adults. Available for dependent children up to age 26.

List of Primary Covered Services & Limitations*

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

Plan Type	How Many/How Often
Type A — Preventive	
Prophylaxis (cleanings)	Two per calendar year
Oral Examinations	Two exams per calendar year
Topical Fluoride Applications	One fluoride treatment per calendar year for dependent children up to his/her 14th birthday
X-rays	Bitewings X-rays; one set per calendar year
Type B — Basic Restorative	
Fillings	<ul style="list-style-type: none"> Amalgams; Once every 24 months, per surface area Composites
Simple Extractions	
Endodontics	Pulp Caps, Pulpotomy and Pulpal Therapy



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Periodontics	<ul style="list-style-type: none"> • Periodontal scaling and root planing once per quadrant, every 24 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year
Space Maintainers	Space maintainers for dependent children up to his/her 14th birthday. Once per tooth area, per lifetime
Sealants	One application of sealant material every 60 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 16th birthday
Type C — Major Restorative	
Surgical Extractions	
Crown, Denture and Bridge Repair/ Recementations	<ul style="list-style-type: none"> • Repairs; Once every 12 months • Recementations; Once every 12 months
Oral Surgery	
Implants	Replacement once every 60 months
Bridges and Dentures	<ul style="list-style-type: none"> • Initial placement to replace one or more natural teeth, which are lost while covered by the plan. Dentures and bridgework replacement; one every 84 months • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns, Inlays and Onlays	Replacement once every 84 months
Endodontics	Root canal treatment
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontics	Periodontal surgery once per quadrant, every 36 months
Type D — Orthodontia	
	<ul style="list-style-type: none"> • You, your spouse and your children, up to age 26, are covered while Dental insurance is in effect • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia • Payments are on a repetitive basis • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary • Orthodontic benefits end at cancellation of coverage

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category, but is not a complete description of the plan.

Exclusions

This plan does not cover the following services, treatments and supplies:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:



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- Scaling and polishing of teeth; or
- Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
 - Covered under any workers' compensation or occupational disease law;
 - Covered under any employer liability law;
 - For which the employer of the person receiving such services is not required to pay; or
 - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
 - Claim form completion;
 - Infection control such as gloves, masks, and sterilization of supplies; or
 - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Initial installation of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders;
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances; and
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture

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Limitations

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

This dental benefits plan is made available through a self-funded arrangement. MetLife administers this dental benefits plan, but does not provide insurance to fund benefits.

Group dental plans featuring the Preferred Dentist Program are provided by Metropolitan Life Insurance Company, New York, NY 10166.

Like most group benefits programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. You may be financially responsible for copayments, deductibles, or any other amounts in excess of those MetLife is required to pay for covered services as described in your dental certificate and/or policy. Ask your MetLife representative for costs and complete details.

Questions & Answers

Q. Who is a participating dentist?

A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 30% – 45% below the average fees charged in a dentist's community for the same or substantially similar services.†

Q. How do I find a participating dentist?

A. There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.

Q. What services are covered under this plan?

A. The Plan documents set forth the services covered by your plan. The List of Primary Covered Services & Limitations herein contains a summary of covered services. In the event of a conflict between the Plan documents and this summary, the terms of the Plan documents shall govern.

Q. May I choose a non-participating dentist?

A. Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist your out-of-pocket costs may be higher.

Q. Can my dentist apply for participation in the network?

A. Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.†† The website and phone number are for use by dental professionals only.

Q. How are claims processed?

A. Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-942-0854

Q. Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?

A. Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of \$300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.



Dental Insurance

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Q. Can MetLife help me find a dentist outside of the U.S. if I am traveling?

A. Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

Q. How does MetLife coordinate benefits with other insurance plans?

A. Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.

Q. Do I need an ID card?

A. No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

†Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.

Savings from enrolling in a dental benefits plan [featuring the MetLife Preferred Dentist Program will depend on various factors, including the cost of the plan, how often participants visit a dentist, and the cost of services rendered.

††Due to contractual requirements, MetLife is prevented from soliciting certain providers.

*AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations. Exclusions: The AXA Travel Assistance Program is available for participants in traveling status. Whenever a trip exceeds 120 days, the participant is no longer considered to be in traveling status and is therefore no longer eligible for the services. Also, AXA Assistance USA will not evacuate or repatriate participants without medical authorization; with mild lesions, simple injuries such as sprains, simple fractures or mild sickness which can be treated by local doctors and do not prevent the member from continuing his/her trip or returning home; or with infections under treatment and not yet healed. Benefits will not be paid for any loss or injury that is caused by or is the result from: pregnancy and childbirth except for complications of pregnancy, and mental and nervous disorders unless hospitalized. Reimbursements for non-medical services such as hotel, restaurant, taxi expenses or baggage loss while traveling are not covered. The maximum benefit per person for costs associated with evacuations, repatriations or the return of mortal remains is US\$500,000. Treatment must be authorized and arranged by AXA Assistance's designated personnel to be eligible for benefits under this program. All services must be provided and arranged by AXA Assistance USA, Inc. No claims for reimbursement will be accepted.

**Refer to your dental benefits plan summary for your out-of-network dental coverage.