2012 Plan Benefits		Deseret Premier Member Pays:		Deseret Protect Member Pays:
Physician Services: Office Visits Routine Adult Physicals Well Child Care	ANNUAL DEDUCTIBLE DOES NOT APPLY	Deseret Premier PCP: $15 per visit Deseret Premier specialist: $25 per visit Non-Deseret Premier PCP: $20 per visit Non-Deseret Premier Specialist: $30 per visit	ANNUAL DEDUCTIBLE DOES NOT APPLY	Deseret Protect PCP: $15 per visit Deseret Protect specialist: $30 per visit Non-Deseret Protect PCP: $20 per visit Non-D. Protect specialist: $35 per visit
Routine Eye Exams		Deseret Premier provider: $25 per visit Non-Deseret Premier provider: $30 per visit One exam is covered every year		100% (not covered)
Outpatient Mental Health Therapy		Deseret Premier provider: $15 for individual and group therapy Non-Deseret Premier provider: $20 for individual and group therapy		Deseret Protect provider: $15 for individual or group therapy Non-Deseret Protect provider: $20 for individual or group therapy
Outpatient Laboratory		Nothing		Nothing
Prescription Drugs		Retail formulary drugs: 30% for 30-day supply; Mail-service formulary drugs: 25% for 90-day supply; up to $85 per prescription All non-formulary drugs: 100% (not covered)		Generic drugs: 20% for retail and mail-service (limited list of generic drugs); Brand-name drugs: 50% for retail and mail-service (very limited list of brand-name drugs)
Basic Radiology		Deseret Premier facility: 10% Non-Deseret Premier facility: 20%		Deseret Protect facility: 30% Non-D. Protect facility: 40% Services include: X-rays, mammograms, ultrasounds, and CT scans
Hospital Emergency Room		D. Premier facility: $75 per visit plus 10% Non-D. Premier facility: $75 per visit plus 20%	ANNUAL DEDUCTIBLE APPLIES TO SERVICES FROM NETWORK PROVIDERS ($1,000 PER MEMBER OR $2,000 PER FAMILY) AND NON-NETWORK PROVIDERS ($1,300 PER MEMBER OR $2,600 PER FAMILY)	D. Protect facility: $75 per visit plus 30% Non-D. Protect facility: $75 per visit plus 40%
Inpatient Hospital Services*	ANNUAL DEDUCTIBLE APPLIES TO SERVICES FROM NON-NETWORK PROVIDERS ($300 PER MEMBER OR $600 PER FAMILY)	Deseret Premier facility: 10% Non-Deseret Premier facility: 20%		Deseret Protect facility: 30% Non-Deseret Protect facility: 40%
Inpatient Maternity Services		Deseret Premier facility: 10% Non-Deseret Premier facility: 20%		Deseret Protect facility: 30% Non-Deseret Protect facility: 40%
Inpatient Mental Health Services*		Deseret Premier facility: 10% Non-Deseret Premier facility: 20%		Deseret Protect facility: 30% Non-Deseret Protect facility: 40% Must preauthorize
Major Radiology Services*		Deseret Premier facility: 10% Non-Deseret Premier facility: 20%		Deseret Protect facility: 30%; non-Deseret Protect facility: 40%. Services include: MRIs, MRAs*, PET* and SPECT* scans
Surgery*		Deseret Premier provider: 10% Non-Deseret Premier provider: 20%		Deseret Protect provider: 30% Non-Deseret Protect provider: 40%
Maternity (Physician)		Deseret Premier provider: 10% Non-Deseret Premier provider: 20%		Deseret Protect provider: 30% Non-Deseret Protect provider: 40%
Physical Therapy		Deseret Premier provider: $25 per visit Non-Deseret Premier provider: $30 per visit Up to 25 visits per calendar year		Deseret Protect provider: $30 per visit Non-Deseret Protect provider: $35 per visit. Up to 15 visits per calendar year
Chiropractic Therapy		Deseret Premier provider: $25 per visit Non-Deseret Premier provider: $30 per visit Up to 25 visits per calendar year		Deseret Protect provider: $30 per visit Non-Deseret Protect provider: $35 per visit. Up to 15 visits per calendar year
Medical Equipment*		Deseret Premier provider: 10% Non-Deseret Premier provider: 20%		Deseret Protect provider: 50% Non-Deseret Protect provider: 50%
Your Annual Maximum Out-of-Pocket Cost		$2,000 per person or $4,000 per family. Then the plan pays 100% of eligible charges.		$4,000 per person or $6,000 per family per calendar year. Then the plans pays 100% of eligible charges. The annual deductible does not apply.

* Preauthorization is required for these services. If you do not preauthorize with Deseret Mutual, you must pay up to the first $200 per service (in addition to your annual deductible).

2012 Plan Benefits		Deseret Value Member Pays:
Physician Services: Office Visits Routine Adult Physicals Well Child Care	ANNUAL DEDUCTIBLE DOES NOT APPLY	Deseret Value PCP: $15 per visit Deseret Value specialist: $25 per visit Non-Deseret Value PCP: $20 per visit Non-Deseret Value specialist: $30 per visit
Routine Eye Exams		100% (not covered)
Outpatient Mental Health Therapy		Deseret Value provider: $15 for individual and group therapy Non-Deseret Value provider: $20 for individual and group therapy
Outpatient Laboratory		Nothing
Prescription Drugs		Retail formulary drugs: 50% for 30-day supply Mail-service formulary drugs: 45% for 90-day supply; up to $140 per prescription All non-formulary drugs: 100% (not covered)
Basic Radiology		Deseret Value facility: 30%; non-Deseret Value facility: 40%
Hospital Emergency Room		Deseret Value facility: $75 per visit plus 30%; non-Deseret Value facility: $75 per visit plus 40%
Inpatient Hospital Services*	ANNUAL DEDUCTIBLE APPLIES TO SERVICES FROM NON-NETWORK PROVIDERS ($300 PER MEMBER OR $600 PER FAMILY)	Deseret Value facility: 30%; non-Deseret Value facility: 40%
Inpatient Maternity Services		Deseret Value facility: 30%; non-Deseret Value facility: 40%
Inpatient Mental Health Services*		Deseret Value facility: 30%; non-Deseret Value facility: 40%
Major Radiology Services*		Deseret Value facility: 30%; non-Deseret Value facility: 40%
Surgery*		Deseret Value provider: 30%; non-Deseret Value provider: 40%
Maternity (Physician)		Deseret Value provider: 30%; non-Deseret Value provider: 40%
Physical Therapy		Deseret Value provider: $25 per visit; non-Deseret Value provider: $30 per visit Up to 25 visit per calendar year
Chiropractic Therapy		Deseret Value provider: $25 per visit; non-Deseret Value provider: $30 per visit Up to 25 visit per calendar year
Medical Equipment*		Deseret Value provider: 30%; non-Deseret Value provider: 40%
Your Annual Maximum Out-of-Pocket Cost	$4,000 per person or $6,000 per family. Then the plan pays 100% of eligible charges. The annual deductible does not apply.	

* Preauthorization may be required for these services. If you do not preauthorize with Deseret Mutual, you must pay up to the first $200 per service.

2012 Plan Benefits	Deseret Select Member Pays:	Deseret Choice Member Pays:
Physician Services: Office Visits Routine Adult Physicals Well Child Care	Deseret Select PCP: $15 Deseret Select specialist: $25 per visit Non-Deseret Select provider: 100% (not covered)	Deseret Choice PCP: $15 per visit Deseret Choice specialist: $25 per visit Non-Deseret Choice PCP: $25 per visit Non-Deseret Choice specialist: $35 per visit
Routine Eye Exams	Deseret Select provider: $25 per visit One exam is covered every year Non-Deseret Select provider: 100% (not covered)	Deseret Choice provider: $25 per visit Non-Deseret Choice provider: $35 per visit One exam is covered every year
Outpatient Mental Health Therapy	Deseret Select provider: $15 for individual and group therapy Non-Deseret Select provider: 100% (not covered)	Deseret Choice provider: $15 for individual and group therapy Non-Deseret Choice provider: $25 for individual and group therapy
Outpatient Laboratory	Deseret Select facility: Nothing Non-Deseret Select facility: 100% (not covered)	Deseret Choice facility: Nothing Non-Deseret Choice facility: 30%
Prescription Drugs	Retail formulary drugs: 30% for 30-day supply Mail-order formulary drugs: 25% for 90-day supply; up to $85 per prescription All non-formulary drugs: 100% (not covered)	Retail formulary drugs: 30% for 30-day supply Mail-order formulary drugs: 25% for 90-day supply; up to $85 per prescription All non-formulary drugs: 100% (not covered)
Basic Radiology	Deseret Select facility: 10% Non-Deseret Select facility: 100% (not covered)	Deseret Choice facility: 10% Non-Deseret Choice facility: 40%
Hospital Emergency Room	$75 per visit plus 10%	$75 per visit plus 10%
Inpatient Hospital Services*	Deseret Select facility: 10% Non-Deseret Select facility: 100% (not covered)	Deseret Choice facility: 10% Non-Deseret Choice facility: 40%
Inpatient Maternity Services	Deseret Select facility: 10% Non-Deseret Select facility: 100% (not covered)	Deseret Choice facility: 10% Non-Deseret Choice facility: 40%
Inpatient Mental Health Services*	Deseret Select facility: 10% Non-Deseret Select facility: 100% (not covered)	Deseret Choice facility: 10% Non-Deseret Choice facility: 40%
Major Radiology Services*	Deseret Select facility: 10% Non-Deseret Select facility: 100% (not covered)	Deseret Choice facility: 10% Non-Deseret Choice facility: 40%
Surgery*	Deseret Select provider: 10% Non-Deseret Select provider: 100% (not covered)	Deseret Choice provider: 10% Non-Deseret Choice provider: 40%
Maternity (Physician)	Deseret Select provider: 10% Non-Deseret Select provider: 100% (not covered)	Deseret Choice provider: 10% Non-Deseret Choice provider: 40%
Physical Therapy	Deseret Select provider: $25 per visit Up to 25 visits per calendar year Non-Deseret Select provider: 100% (not covered)	Deseret Choice provider: $25 per visit Non-Deseret Choice provider: $35 per visit Up to 25 visits per calendar year
Chiropractic Therapy	CHP provider: $25 per visit; no visit limit when preauthorized and medically necessary Non-CHP provider: 100% (not covered)	CHP provider: $25 per visit; no visit limit when preauthorized and medically necessary Non-CHP provider: $35 per visit for up to five visits
Medical Equipment*	Deseret Select provider: 10% Non-Deseret Select provider: 100% (not covered)	Deseret Choice provider: 10% Non-Deseret Choice provider: 40%
Your Annual Maximum Out-of-Pocket Cost	$2,000 per person or $4,000 per family ***for services from Deseret Select providers***. Then the plan pays 100% of eligible charges.	$2,000 per person or $4,000 per family ***for services from Deseret Choice providers***. Then the plan pays 100% of eligible charges.

* Preauthorization may be required for these services. If you do not preauthorize with Deseret Mutual, you must pay up to the first $200 per service.