Select Health

MED NETWORK / HSA QUALIFIED

MEMBER PAYMENT SUMMARY	IN-NETWORK When using In-Network Providers, you are responsible to pay the amounts in this column.	OUT-OF-NETWORK When using Out-of-Network Providers, you are responsible to pay the amounts in this column.
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar Year		
Deductible	$2,500	$2,750
Out-of-Pocket Maximum	$4,500	$6,000
Family Coverage, 2 or more enrolled - per calendar Year		
Deductible	$5,000	$5,500
Out-of-Pocket Maximum - per person/family	$4500/$9000	$6000/$12000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical and Hospice[4]	20% after Deductible	40% after Deductible
Hospital Level Care at Home[4]	20% after Deductible	Not Covered
Skilled Nursing Facility[4] - Up to 60 days per calendar Year	20% after Deductible	40% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after Deductible	40% after Deductible
Up to 40 days per calendar Year for all therapy types combined		
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible	40% after Deductible
PROFESSIONAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	$20 after Deductible	40% after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100% after Deductible	Not Covered
Specialist/Secondary Care Provider (SCP)[1]	$30 after Deductible	40% after Deductible
Allergy Tests	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20% after Deductible	Not Covered
Major Surgery	20% after Deductible	40% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible	40% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	Not Covered
Specialist/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
VISION SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Preventive Eye Exams	Covered 100%	Not Covered
All Other Eye Exams	$30 after Deductible	40% after Deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility	20% after Deductible	40% after Deductible
Ambulatory Surgical Center	10% after Deductible	40% after Deductible
Imaging Center	10% after Deductible	40% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after Deductible	See In-Network Benefit
Emergency Room	$75 after Deductible	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$40 after Deductible	40% after Deductible
Intermountain KidsCare® Facilities	$20 after Deductible	Not Available
Intermountain Connect Care®	Covered 100% after Deductible	Not Available
Radiation	20% after Deductible	40% after Deductible
Dialysis	20% after Deductible	40% after Deductible
Diagnostic Tests: Minor[2]	Covered 100% after Deductible	40% after Deductible
Diagnostic Tests: Major[2]	20% after Deductible	40% after Deductible
Home Health, Hospice, Outpatient Private Nurse	20% after Deductible	40% after Deductible
Outpatient Cardiac Rehab	Covered 100% after Deductible	40% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$30 after Deductible	40% after Deductible

See other side for additional benefits

Select Health

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MEMBER PAYMENT SUMMARY	IN-NETWORK	OUT-OF-NETWORK
MISCELLANEOUS SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME)[4]	20% after Deductible	40% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after Deductible	40% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity and Adoption[4,7]	See Professional, Inpatient or Outpatient	40% after Deductible
Cochlear Implants or Auditory Osseointegrated Devices[2,4] *One device every 36 months per ear*	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services*	50% after Deductible	Not Covered
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	Not Covered
OPTIONAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Substance Use Disorder[4]		
Office Visits	$20 after Deductible	40% after Deductible
Virtual Visits	Covered 100% after Deductible	40% after Deductible
Inpatient	20% after Deductible	40% after Deductible
Outpatient	20% after Deductible	40% after Deductible
Residential Treatment[2]	20% after Deductible	40% after Deductible
Chiropractic *(up to 20 visits per calendar Year)*	$20 after Deductible	Not Covered
Healthcare Provider Administered Injectable or Infusible Drugs[4]	20% after Deductible	40% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	Not Covered
PRESCRIPTION DRUGS		
Prescription Drug List (formulary)	RxSelect®	
Prescription Drugs-*Up to 30 Day Supply of Covered Medications*[4]		
Tier 1	$10 after In-Network Deductible	
Tier 2	$25 after In-Network Deductible	
Tier 3	$45 after In-Network Deductible	
Tier 4	$100 after In-Network Deductible	
Maintenance Drugs-*90 Day Supply (Mail-Order,Retail90®)-selected drugs*[4]		
Tier 1	$10 after In-Network Deductible	
Tier 2	$50 after In-Network Deductible	
Tier 3	$135 after In-Network Deductible	
Deductible Waiver	Certain prescription drugs are not subject to the Deductible	
Generic Substitution Required	Generic required or must pay Copay plus cost difference between name brand and generic	

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 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.

5 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.

6 Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.

7 SelectHealth provides a $4000 adoption indemnity as outlined by the state of Utah. Medical Deductible, Copay, or Coinsurance listed under the benefit applies and may exhaust the benefits prior to any plan payments.

Select Health will cover an insulin from each therapeutic category with a cap of $25 per prescription of a 30-day supply.

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, Inc. [SM] ***(domiciled in Utah).***