Select Health

VALUE NETWORK / HSA QUALIFIED

MEMBER PAYMENT SUMMARY

IN-NETWORK

When using In-Network Providers, you are responsible to pay the amounts in this column. Services from Out-of-Network Providers are not covered (except emergencies).

MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	IN-NETWORK
Self Only Coverage, 1 person enrolled - per calendar Year	
Deductible	$3,500
Out-of-Pocket Maximum	$6,900
Family Coverage, 2 or more enrolled - per calendar Year	
Deductible	$7,000
Out-of-Pocket Maximum - per person/family	$6,900/$13,800
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)	
INPATIENT SERVICES	**IN-NETWORK**
Medical, Surgical and Hospice[4]	20% after Deductible
Hospital Level Care at Home[4]	20% after Deductible
Skilled Nursing Facility[4] - Up to 60 days per calendar Year	20% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after Deductible
Up to 40 days per calendar Year for all therapy types combined	
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible
PROFESSIONAL SERVICES	**IN-NETWORK**
Office Visits & Minor Office Surgeries	
Primary Care Provider (PCP)[1]	20% after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100% after Deductible
Specialist/Secondary Care Provider (SCP)[1]	20% after Deductible
Allergy Tests	See Office Visits Above
Allergy Treatment and Serum	20% after Deductible
Major Surgery	20% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%
Specialist/Secondary Care Provider (SCP)[1]	Covered 100%
Adult and Pediatric Immunizations	Covered 100%
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%
Diagnostic Tests: Minor	Covered 100%
Other Preventive Services	Covered 100%
VISION SERVICES	**IN-NETWORK**
Preventive Eye Exams	Covered 100%
All Other Eye Exams	20% after Deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**
Outpatient Facility	20% after Deductible
Ambulatory Surgical Center	10% after Deductible
Imaging Center	10% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after Deductible
Emergency Room	20% after Deductible
Intermountain InstaCare® Facilities, Urgent Care Facilities	20% after Deductible
Intermountain KidsCare® Facilities	20% after Deductible
Intermountain Connect Care®	Covered 100% after Deductible
Radiation	20% after Deductible
Dialysis	20% after Deductible
Diagnostic Tests: Minor[2]	Covered 100% after Deductible
Diagnostic Tests: Major[2]	20% after Deductible
Home Health, Hospice, Outpatient Private Nurse	20% after Deductible
Outpatient Cardiac Rehab	Covered 100% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	20% after Deductible

See other side for additional benefits

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IN-NETWORK

MISCELLANEOUS SERVICES	IN-NETWORK
Durable Medical Equipment (DME)[4]	20% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Substance Use Disorder Services
Maternity and Adoption[4,7]	See Professional, Inpatient or Outpatient
Cochlear Implants or Auditory Osseointegrated Devices[2,4] *One device every 36 months per ear*	See Professional, Inpatient or Outpatient
Infertility - *Selected Services*	50% after Deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient
OPTIONAL BENEFITS	**IN-NETWORK**
Mental Health and Substance Use Disorder[4]	
Office Visits	20% after Deductible
Virtual Visits	Covered 100% after Deductible
Inpatient	20% after Deductible
Outpatient	20% after Deductible
Residential Treatment[2]	20% after Deductible
Chiropractic *(up to 20 visits per calendar Year)*	20% after Deductible
Healthcare Provider Administered Injectable or Infusible Drugs[4]	20% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)* [4]	See Professional, Inpatient or Outpatient
PRESCRIPTION DRUGS	
Prescription Drug List (formulary)	RxSelect®
Prescription Drugs - *Up to 30 Day Supply of Covered Medications* [4]	
Tier 1	$10 after Deductible
Tier 2	$25 after Deductible
Tier 3	$45 after Deductible
Tier 4	$100 after Deductible
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90®)-selected drugs* [4]	
Tier 1	$10 after Deductible
Tier 2	$50 after Deductible
Tier 3	$135 after Deductible
Generic Substitution Required	Generic required or must pay Copay plus cost difference between name brand and generic

1 Refer to **selecthealth.org/find-care** 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 Select Health 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 $10 per prescription of a 30-day supply.

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.℠ (domiciled in Utah).