



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	\$3,000
Out-of-Pocket Maximum	\$5,000
Family Coverage, 2 or more enrolled - per calendar Year	
Deductible - per person/family	\$3,000/\$6,000
Out-of-Pocket Maximum - per person/family	\$5,000/\$10,000
(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	\$30
Primary Care Provider (PCP) Virtual Visits ¹	Covered 100%
Specialist/Secondary Care Provider (SCP) ¹	\$40
Allergy Tests	See Office Visits Above
Allergy Treatment and Serum	20%
Major Surgery	20%
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	\$40
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	\$300 after Deductible
Intermountain InstaCare [®] Facilities, Urgent Care Facilities	\$50
Intermountain KidsCare [®] Facilities	\$30
Intermountain Connect Care [®]	Covered 100%
Radiation	20% after Deductible
Dialysis	20% after Deductible
Diagnostic Tests: Minor ²	Covered 100%
Diagnostic Tests: Major ²	20% after Deductible
Home Health, Hospice, Outpatient Private Nurse	20% after Deductible
Outpatient Cardiac Rehab	Covered 100%
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	\$40 after Deductible



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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} <i>One device every 36 months per ear</i>	See Professional, Inpatient or Outpatient
Infertility - Select Services	50% after Deductible
TMJ (Temporomandibular Joint) Services - <i>Up to \$2,000 lifetime</i>	See Professional, Inpatient or Outpatient
OPTIONAL BENEFITS	IN-NETWORK
Mental Health and Substance Use Disorder ⁴	
Office Visits	\$30
Virtual Visits	Covered 100%
Inpatient	20% after Deductible
Outpatient	20%
Residential Treatment ²	20% after Deductible
Chiropractic <i>(up to 20 visits per calendar Year)</i>	\$20
Healthcare Provider Administered Injectable or Infusible Drugs ⁴	20% after Deductible
Bariatric Surgery <i>(Up to one surgery/lifetime)</i> ⁴	See Professional, Inpatient or Outpatient
PRESCRIPTION DRUGS	
Pharmacy Deductible - Per Person per calendar Year	\$500
Prescription Drug List (formulary)	RxSelect®
Prescription Drugs - <i>Up to 30 Day Supply of Covered Medications</i> ⁴	
Tier 1	\$15
Tier 2	\$30 after pharmacy Deductible
Tier 3	\$50 after pharmacy Deductible
Tier 4	\$100 after pharmacy Deductible
Maintenance Drugs - <i>90 Day Supply (Mail-Order, Retail90®)-selected drugs</i> 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

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.

* Not applied to Medical Out-of-Pocket Maximum.

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).

UT MPS-HMO 01/01/26

10/08/25

selecthealth.org