



MEMBER PAYMENT SUMMARY	
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.

CONDITIONS AND LIMITATIONS		
Lifetime Maximum Plan Payment - <i>Per Person</i>	None	
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	plan Year	
Maximum Annual Out-of-Network Payment - (per plan Year)	None	None
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET ^{5,6}	IN-NETWORK	OUT-OF-NETWORK
Self Only Coverage, 1 person enrolled - per plan Year		
Deductible	\$2,500	\$2,750
Out-of-Pocket Maximum	\$4,000	\$5,500
Family Coverage, 2 or more enrolled - per plan Year		
Deductible	\$5,000	\$5,500
Out-of-Pocket Maximum	\$6,850	\$11,000
(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
Skilled Nursing Facility ⁴ - Up to 60 days per plan Year	20% after Deductible	40% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational ⁴ Up to 40 days per plan Year for all therapy types combined	20% after Deductible	40% after Deductible
PROFESSIONAL SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP) ¹	\$15 after Deductible	40% after Deductible
Secondary Care Provider (SCP) ¹	\$25 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
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	\$25 after Deductible	40% after Deductible
OUTPATIENT SERVICES ⁴	IN-NETWORK	OUT-OF-NETWORK
Outpatient Facility and Ambulatory Surgical	20% after Deductible	40% after Deductible
Ambulance (Air or Ground) - <i>Emergencies Only</i>	20% after Deductible	See In-Network Benefit
Emergency Room - (<i>In-Network facility</i>)	\$75 after Deductible	See In-Network Benefit
Emergency Room - (<i>Out-of-Network facility</i>)	\$75 after Deductible	See In-Network Benefit
Intermountain InstaCare [®] Facilities, Urgent Care Facilities	\$35 after Deductible	40% after Deductible
Intermountain KidsCare [®] Facilities	\$15 after Deductible	Not Available
Intermountain Connect Care [®]	Covered 100%	Not Available
Chemotherapy, Radiation and 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	\$25 after Deductible	40% after Deductible



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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 ⁴	See Professional, Inpatient or Outpatient	Not Covered
Infertility - <i>Select Services</i>	50% after Deductible	Not Covered
Donor Fees for Covered Organ Transplants ⁴	20% after Deductible	Not Covered
TMJ (Temporomandibular Joint) Services - <i>Up to \$2,000 lifetime</i>	See Professional, Inpatient or Outpatient	Not Covered
OPTIONAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Mental Health and Chemical Dependency ⁴		
Office Visits	\$15 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
Injectable Drugs and Specialty Medications ⁴	20% after Deductible	40% after Deductible
Bariatric Surgery (<i>Up to one surgery/lifetime</i>) ⁴	See Professional, Inpatient or Outpatient	Not Covered
PRESCRIPTION DRUGS		
Prescription Drug List (formulary)	RxSelect [®]	
Prescription Drugs- <i>Up to 30 Day Supply of Covered Medications</i> ⁴		
Tier 1	\$7 after In-Network Deductible	
Tier 2	\$21 after In-Network Deductible	
Tier 3	\$42 after In-Network Deductible	
Tier 4	\$100 after In-Network Deductible	
Maintenance Drugs- <i>90 Day Supply (Mail-Order, Retail⁹⁰®)-selected drugs</i> ⁴		
Tier 1	\$7 after In-Network Deductible	
Tier 2	\$42 after In-Network Deductible	
Tier 3	\$126 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 amounts and not on the Providers billed charges. Out-of-Network Providers or Facilities have not agreed to accept the Allowed Amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

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.

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).