selecthealth SHARE

	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).
CONDITIONS AND LIMITATIONS	
Lifetime Maximum Plan Payment - *Per Person*	None
Pre-Existing Conditions (PEC)	None
Benefit Accumulator Period	plan Year
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	**IN-NETWORK**
Self Only Coverage, 1 person enrolled - per plan Year	
Deductible	$1,500
Out-of-Pocket Maximum	$4,000
Family Coverage, 2 or more enrolled - per plan Year	
Deductible - per person/family	$1500/$4500
Out-of-Pocket Maximum - per person/family	$4000/$8000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)	
INPATIENT SERVICES	**IN-NETWORK**
Medical, Surgical and Hospice[4]	$350 per admit, then 20% after Deductible
Skilled Nursing Facility[4] - Up to 60 days per plan Year	$350 per admit, then 20% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after Deductible
Up to 40 days per plan Year for all therapy types combined	
PROFESSIONAL SERVICES	**IN-NETWORK**
Office Visits & Minor Office Surgeries	
Primary Care Provider (PCP)[1]	$25
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%
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 and Ambulatory Surgical	20% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after Deductible
Emergency Room - *(In-Network facility)*	$250 after Deductible
Emergency Room - *(Out-of-Network facility)*	$250 after Deductible
Intermountain InstaCare® Facilities, Urgent Care Facilities	$40
Intermountain KidsCare® Facilities	$25
Intermountain Connect Care®	Covered 100%
Chemotherapy, Radiation and 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

See other side for additional benefits

selecthealth SHARE

MEMBER PAYMENT SUMMARY

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 Chemical Dependency Services
Maternity and Adoption[4,7]	See Professional, Inpatient or Outpatient
Cochlear Implants[4]	See Professional, Inpatient or Outpatient
Infertility - *Select Services*	50% after Deductible
Donor Fees for Covered Organ Transplants[4]	20% after Deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient
OPTIONAL BENEFITS	**IN-NETWORK**
Mental Health and Chemical Dependency[4]	
Office Visits	$25
Inpatient	$350 per admit, then 20% after Deductible
Outpatient	20%
Residential Treatment[2]	$350 per admit, then 20% after Deductible
Injectable Drugs and Specialty Medications[4]	20% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient
PRESCRIPTION DRUGS	
Pharmacy Deductible - Per Person per plan Year	$100
Prescription Drug List (formulary)	RxSelect®
Prescription Drugs - *Up to 30 Day Supply of Covered Medications*[4]	
Tier 1	$15
Tier 2	$30 after pharmacy Deductible
Tier 3	$50 after pharmacy Deductible
Tier 4	$100 after pharmacy Deductible
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90®)-selected drugs*[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/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.

* 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).***