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] — Covered 100% after Deductible
Skilled Nursing Facility[4] - Up to 60 days per plan Year — Covered 100% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4] — Covered 100% after Deductible
Up to 40 days per plan Year for all therapy types combined
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)* — Covered 100% after Deductible
PROFESSIONAL SERVICES — **IN-NETWORK**
Office Visits & Minor Office Surgeries
Primary Care Provider (PCP)[1] — Covered 100%
Primary Care Provider (PCP) Virtual Visits[1] — Covered 100%
Secondary Care Provider (SCP)[1] — Covered 100%
Allergy Tests — See Office Visits Above
Allergy Treatment and Serum — Covered 100%
Major Surgery — Covered 100%
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)* — Covered 100% 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 — Covered 100%
OUTPATIENT SERVICES[4] — **IN-NETWORK**
Outpatient Facility and Ambulatory Surgical — Covered 100% after Deductible
Ambulance (Air or Ground) - *Emergencies Only* — Covered 100% after Deductible
Emergency Room - *(In-Network facility)* — Covered 100% after Deductible
Emergency Room - *(Out-of-Network facility)* — Covered 100% after Deductible
Intermountain InstaCare® Facilities, Urgent Care Facilities — Covered 100%
Intermountain KidsCare® Facilities — Covered 100%
Intermountain Connect Care® — Covered 100%
Radiation and Dialysis — Covered 100% after Deductible
Diagnostic Tests: Minor[2] — Covered 100%
Diagnostic Tests: Major[2] — Covered 100% after Deductible
Home Health, Hospice, Outpatient Private Nurse — Covered 100% after Deductible
Outpatient Cardiac Rehab — Covered 100%
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational — Covered 100% after Deductible

See other side for additional benefits

selecthealth SHARE

MEMBER PAYMENT SUMMARY
IN-NETWORK

MISCELLANEOUS SERVICES	IN-NETWORK
Durable Medical Equipment (DME)[4]	Covered 100% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	Covered 100% 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, Hearing Aids, or Auditory Osseointegrated Devices[2,4] *One device every 36 months per ear*	See Professional, Inpatient or Outpatient
Infertility - *Select Services*	50% after Deductible
Donor Fees for Covered Organ Transplants[4]	Covered 100% 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	Covered 100%
Virtual Visits	Covered 100%
Inpatient	Covered 100% after Deductible
Outpatient	Covered 100%
Residential Treatment[2]	Covered 100% after Deductible
Injectable Drugs, Chemotherapy, and Specialty Medications[4]	Covered 100% 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	Covered 100%
Tier 2	Covered 100% after pharmacy Deductible
Tier 3	Covered 100% after pharmacy Deductible
Tier 4	Covered 100% after pharmacy Deductible
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90 ®)-selected drugs* [4]	
Tier 1	Covered 100%
Tier 2	Covered 100% after pharmacy Deductible
Tier 3	Covered 100% 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).