LEXINGTON LAW — OPTION 1 — 01/01/2023

selecthealth MED NETWORK

	MEMBER PAYMENT SUMMARY	
	IN-NETWORK When using In-Network Providers, you are responsible to pay the amounts in this column.	**OUT-OF-NETWORK** When using Out-of-Network Providers, you are responsible to pay the amounts in this column.
CONDITIONS AND LIMITATIONS		
Lifetime Maximum Plan Payment - *Per Person*	None	
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	calendar Year	
Maximum Annual Out-of-Network Payment - (per calendar Year)	None	None
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar Year		
Deductible	$1,250	$2,500
Out-of-Pocket Maximum	$4,500	$9,000
Family Coverage, 2 or more enrolled - per calendar Year		
Deductible - per person/family	$1250/$2500	$2500/$5000
Out-of-Pocket Maximum - per person/family	$4500/$9000	$9000/$18000
(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	50% after Deductible
Hospital Level Care at Home[4]	20% after Deductible	Not Covered
Skilled Nursing Facility[4] - Up to 60 days per calendar Year	20% after Deductible	50% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4] Up to 40 days per calendar Year for all therapy types combined	20% after Deductible	50% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible	50% after Deductible
PROFESSIONAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	$25	50% after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100%	Not Covered
Specialist/Secondary Care Provider (SCP)[1]	$50	50% after Deductible
Allergy Tests	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Major Surgery	20%	50% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible	50% 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
Specialist/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	$50	50% after Deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility	20% after Deductible	50% after Deductible
Ambulatory Surgical Center	20% after Deductible	50% after Deductible
Imaging Center	20% after Deductible	50% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after Deductible	See In-Network Benefit
Emergency Room	$500 after Deductible	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$50	50% after Deductible
Intermountain KidsCare® Facilities	$25	Not Available
Intermountain Connect Care®	Covered 100%	Not Available
Radiation	20% after Deductible	50% after Deductible
Dialysis	20% after Deductible	50% after Deductible
Diagnostic Tests: Minor[2]	Covered 100%	50% after Deductible
Diagnostic Tests: Major[2]	20% after Deductible	50% after Deductible
Home Health, Hospice, Outpatient Private Nurse	20% after Deductible	50% after Deductible
Outpatient Cardiac Rehab	Covered 100%	50% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$50 after Deductible	50% after Deductible

See other side for additional benefits

selecthealth
MED NETWORK

	MEMBER PAYMENT SUMMARY	
	IN-NETWORK	**OUT-OF-NETWORK**
MISCELLANEOUS SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME)[4]	20% after Deductible	50% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after Deductible	50% 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	50% after Deductible
Cochlear Implants or Auditory Osseointegrated Devices[2,4] *One device every 36 months per ear*	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services*	50% after Deductible	Not Covered
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	Not Covered
OPTIONAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Chemical Dependency[4]		
Office Visits	$25	50% after Deductible
Virtual Visits	Covered 100%	50% after Deductible
Inpatient	20% after Deductible	50% after Deductible
Outpatient	20%	50% after Deductible
Residential Treatment[2]	20% after Deductible	50% after Deductible
Chiropractic *(up to 20 visits per calendar Year)*	$25	Not Covered
Injectable Drugs, Chemotherapy, and Specialty Medications[4]	20% after Deductible	50% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	Not Covered
PRESCRIPTION DRUGS		
Prescription Drug List (formulary)	RxSelect®	
Prescription Drugs - *Up to 30 Day Supply of Covered Medications*[4]		
Tier 1	$15	
Tier 2	$40	
Tier 3	$60	
Tier 4	$100	
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90®)-selected drugs*[4]		
Tier 1	$15	
Tier 2	$80	
Tier 3	$180	
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 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 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.

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.℠ (domiciled in Utah).