



| 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   | calendar Year                 |                        |
| Maximum Annual Out-of-Network Payment - (per calendar Year)  | None                          | None                   |
| MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET <sup>5,6</sup>  | IN-NETWORK                    | OUT-OF-NETWORK         |
| Self Only Coverage, 1 person enrolled - per calendar Year  |                               |                        |
| Deductible   | \$4,500                       | \$7,400                |
| Out-of-Pocket Maximum  | \$6,000                       | \$8,000                |
| Family Coverage, 2 or more enrolled - per calendar Year  |                               |                        |
| Deductible - per person/family   | \$4500/\$9000                 | \$7400/\$14800         |
| Out-of-Pocket Maximum - per person/family  | \$6000/\$12000                | \$8000/\$16000         |
| (Medical and Pharmacy Included in the Out-of-Pocket Maximum)   |                               |                        |
| INPATIENT SERVICES   | IN-NETWORK                    | OUT-OF-NETWORK         |
| Medical, Surgical and Hospice <sup>4</sup>   | 30% after Deductible          | 50% after Deductible   |
| Hospital Level Care at Home <sup>4</sup>   | 30% after Deductible          | Not Covered            |
| Skilled Nursing Facility <sup>4</sup> - Up to 60 days per calendar Year  | 30% after Deductible          | 50% after Deductible   |
| Inpatient Rehab Therapy: Physical, Speech, Occupational <sup>4</sup><br>Up to 40 days per calendar Year for all therapy types combined | 30% after Deductible          | 50% after Deductible   |
| Physician's Fees - (Medical, Surgical, Maternity, Anesthesia)  | 30% after Deductible          | 50% after Deductible   |
| PROFESSIONAL SERVICES  | IN-NETWORK                    | OUT-OF-NETWORK         |
| Office Visits & Minor Office Surgeries   |                               |                        |
| Primary Care Provider (PCP) <sup>1</sup>   | 30% after Deductible          | 50% after Deductible   |
| Primary Care Provider (PCP) Virtual Visits <sup>1</sup>  | Covered 100% after Deductible | Not Covered            |
| Specialist/Secondary Care Provider (SCP) <sup>1</sup>  | 30% after Deductible          | 50% after Deductible   |
| Allergy Tests  | See Office Visits Above       | Not Covered            |
| Allergy Treatment and Serum  | 30% after Deductible          | Not Covered            |
| Major Surgery  | 30% after Deductible          | 50% after Deductible   |
| Physician's Fees - (Medical, Surgical, Maternity, Anesthesia)  | 30% after Deductible          | 50% after Deductible   |
| PREVENTIVE SERVICES AS OUTLINED BY THE ACA <sup>2,3</sup>  | IN-NETWORK                    | OUT-OF-NETWORK         |
| Primary Care Provider (PCP) <sup>1</sup>   | Covered 100%                  | Not Covered            |
| Specialist/Secondary Care Provider (SCP) <sup>1</sup>  | 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  | 30% after Deductible          | 50% after Deductible   |
| OUTPATIENT SERVICES <sup>4</sup>   | IN-NETWORK                    | OUT-OF-NETWORK         |
| Outpatient Facility  | 30% after Deductible          | 50% after Deductible   |
| Ambulatory Surgical Center   | 30% after Deductible          | 50% after Deductible   |
| Imaging Center   | 30% after Deductible          | 50% after Deductible   |
| Ambulance (Air or Ground) - <i>Emergencies Only</i>  | 30% after Deductible          | See In-Network Benefit |
| Emergency Room   | 30% after Deductible          | See In-Network Benefit |
| Intermountain InstaCare <sup>®</sup> Facilities, Urgent Care Facilities  | 30% after Deductible          | 50% after Deductible   |
| Intermountain KidsCare <sup>®</sup> Facilities   | 30% after Deductible          | Not Available          |
| Intermountain Connect Care <sup>®</sup>  | Covered 100% after Deductible | Not Available          |
| Radiation  | 30% after Deductible          | 50% after Deductible   |
| Dialysis   | 30% after Deductible          | 50% after Deductible   |
| Diagnostic Tests: Minor <sup>2</sup>   | Covered 100% after Deductible | 50% after Deductible   |
| Diagnostic Tests: Major <sup>2</sup>   | 30% after Deductible          | 50% after Deductible   |
| Home Health, Hospice, Outpatient Private Nurse   | 30% after Deductible          | 50% after Deductible   |
| Outpatient Cardiac Rehab   | Covered 100% after Deductible | 50% after Deductible   |
| Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational  | 30% after Deductible          | 50% after Deductible   |



**MEMBER PAYMENT SUMMARY**

| IN-NETWORK | OUT-OF-NETWORK |
|------------|----------------|
|------------|----------------|

**MISCELLANEOUS SERVICES**

|   | IN-NETWORK   | OUT-OF-NETWORK   |
|---|--|--|
| Durable Medical Equipment (DME) <sup>4</sup>  | 30% after Deductible   | 50% after Deductible   |
| Miscellaneous Medical Supplies (MMS) <sup>3</sup>   | 30% 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 <sup>4,7</sup>   | See Professional, Inpatient or Outpatient  | 50% after Deductible   |
| Cochlear Implants or Auditory Osseointegrated Devices <sup>2,4</sup><br><i>One device every 36 months per ear</i> | See Professional, Inpatient or Outpatient  | Not Covered  |
| Infertility - <i>Select Services</i>  | 50% 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 <sup>4</sup>                     |   |                      |
| Office Visits  | 30% after Deductible                      | 50% after Deductible |
| Virtual Visits   | Covered 100% after Deductible             | 50% after Deductible |
| Inpatient  | 30% after Deductible                      | 50% after Deductible |
| Outpatient   | 30% after Deductible                      | 50% after Deductible |
| Residential Treatment <sup>2</sup>                                     | 30% after Deductible                      | 50% after Deductible |
| Chiropractic<br><i>(up to 20 visits per calendar Year)</i>             | 30% after Deductible                      | Not Covered          |
| Injectable Drugs, Chemotherapy, and Specialty Medications <sup>4</sup> | 30% after Deductible                      | 50% after Deductible |
| Bariatric Surgery <i>(Up to one surgery/lifetime)</i> <sup>4</sup>     | See Professional, Inpatient or Outpatient | Not Covered          |

**PRESCRIPTION DRUGS**

|  | RxSelect <sup>®</sup>  |
|--|--|
| Prescription Drug List (formulary)   |  |
| Prescription Drugs- <i>Up to 30 Day Supply of Covered Medications</i> <sup>4</sup>                     |  |
| Tier 1   | 30% after In-Network Deductible  |
| Tier 2   | 30% after In-Network Deductible  |
| Tier 3   | 30% after In-Network Deductible  |
| Tier 4   | 30% after In-Network Deductible  |
| Maintenance Drugs- <i>90 Day Supply (Mail-Order, Retail90<sup>®</sup>)-selected drugs</i> <sup>4</sup> |  |
| Tier 1   | 30% after In-Network Deductible  |
| Tier 2   | 30% after In-Network Deductible  |
| Tier 3   | 30% 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](https://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.  
 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).