Select Health

VALUE AND MED NETWORKS / HSA QUALIFIED

Administered by SelectHealth

SCHEDULE OF BENEFITS	TIER 1 VALUE When using In-Network Providers, you are responsible to pay the amounts in this column. These providers might not be available in all areas.	TIER 2 MED 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.
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar Year			
Deductible	$2,500		$2,500
Out-of-Pocket Maximum	$4,000		$8,500
Family Coverage, 2 or more enrolled - per calendar Year			
Deductible	$5,000		$5,000
Out-of-Pocket Maximum	$8,000		$17,000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)			
INPATIENT SERVICES	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical and Hospice[4]	10% after Deductible	10% after Deductible	30% after Deductible
Hospital Level Care at Home[4]	10% after Deductible	10% after Deductible	Not Covered
Skilled Nursing Facility[4] - Up to 60 days per calendar Year	10% after Deductible	10% after Deductible	30% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	10% after Deductible	10% after Deductible	30% after Deductible
Up to 40 days per calendar Year for all therapy types combined			
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	10% after Deductible	10% after Deductible	30% after Deductible
PROFESSIONAL SERVICES	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries			
Primary Care Provider (PCP)[1]	$25 after Deductible	$25 after Deductible	30% after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100% after Deductible	Covered 100% after Deductible	Not Covered
Specialist/Secondary Care Provider (SCP)[1]	$35 after Deductible	$35 after Deductible	30% after Deductible
Salt Lake County HealthyMe Medical Clinic	$30 each visit, then $10 after Deductible		Not Covered
Allergy Tests	See Office Visits Above	See Office Visits Above	30% after Deductible
Allergy Treatment and Serum	10% after Deductible	10% after Deductible	30% after Deductible
Major Surgery	10% after Deductible	10% after Deductible	30% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	10% after Deductible	10% after Deductible	30% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	Covered 100%	Not Covered
Specialist/Secondary Care Provider (SCP)[1]	Covered 100%	Covered 100%	Not Covered
Salt Lake County HealthyMe Medical Clinic	Covered 100%	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Covered 100%	Not Covered
VISION SERVICES	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Preventive Eye Exams	Covered 100%	Covered 100%	Not Covered
All Other Eye Exams	$35 after Deductible	$35 after Deductible	30% after Deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility	10% after Deductible	10% after Deductible	30% after Deductible
Ambulatory Surgical Center	10% after Deductible	10% after Deductible	30% after Deductible
Imaging Center	10% after Deductible	10% after Deductible	30% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	10% after Deductible	See In-Network Benefit	See In-Network Benefit
Emergency Room	$150 after Deductible	See In-Network Benefit	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$45 after Deductible	$45 after Deductible	30% after Deductible
Intermountain KidsCare® Facilities	$25 after Deductible	$25 after Deductible	Not Available
Intermountain Connect Care®	Covered 100% after Deductible	Covered 100% after Deductible	Not Available
Radiation	10% after Deductible	10% after Deductible	30% after Deductible
Dialysis	10% after Deductible	10% after Deductible	30% after Deductible
Diagnostic Tests: Minor[2]	Covered 100% after Deductible	Covered 100% after Deductible	30% after Deductible
Diagnostic Tests: Major[2]	10% after Deductible	10% after Deductible	30% after Deductible
Home Health, Hospice, Outpatient Private Nurse	Covered 100% after Deductible	Covered 100% after Deductible	30% after Deductible
Up to 60 visits per calendar Year			
Outpatient Cardiac Rehab	Covered 100% after Deductible	Covered 100% after Deductible	30% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$35 after Deductible	$35 after Deductible	30% after Deductible

See other side for additional benefits

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	SCHEDULE OF BENEFITS		
	TIER 1 VALUE	**TIER 2 MED**	**OUT-OF-NETWORK**
MISCELLANEOUS SERVICES	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME)[4]	10% after Deductible	10% after Deductible	30% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	10% after Deductible	10% after Deductible	30% after Deductible
Autism Spectrum Disorder	10% after Deductible	10% after Deductible	Not Covered
Maternity[4]	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	30% after Deductible
Cochlear Implants[4]	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services*	50% after Deductible	50% after Deductible	50% after Deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	50% after Deductible	50% after Deductible	50% after Deductible
OTHER BENEFITS	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Substance Use Disorder[4]			
Office Visits	$35 after Deductible	$35 after Deductible	30% after Deductible
Virtual Visits	Covered 100% after Deductible	Covered 100% after Deductible	30% after Deductible
Inpatient	10% after Deductible	10% after Deductible	30% after Deductible
Outpatient	10% after Deductible	10% after Deductible	30% after Deductible
Residential Treatment[2]	10% after Deductible	10% after Deductible	30% after Deductible
Gender Dysphoria	See Professional, Inpatient or Outpatient and Mental Health Services	See Professional, Inpatient or Outpatient and Mental Health Services	30% after Deductible
Chiropractic	$35 after In-Network Deductible		
Adoption[4,7]	Covered 100% for 1st $4000		
Healthcare Provider Administered Injectable or Infusible Drugs[4]	20% after Deductible	20% after Deductible	30% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	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	$10 after In-Network Deductible		
Tier 2	25% with a minimum of $25 and maximum of $75 after In-Network Deductible		
Tier 3	50% with a minimum of $50 and maximum of $100 after In-Network Deductible		
Tier 4 (*Must be filled at Intermountain Specialty Pharmacy*)	20% with a maximum of $150 after In-Network Deductible		
Maintenance Drugs-*90 Day Supply (Mail-Order,Retail90®)-selected drugs*[4]			
Tier 1	$20 after In-Network Deductible		
Tier 2	25% with a minimum of $50 and maximum of $150 after In-Network Deductible		
Tier 3	50% with a minimum of $100 and maximum of $200 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 Summary Plan Description 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 Summary Plan Description, 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 Summary Plan Description are not subject to the Deductible.

7 The plan 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.