



VALUE AND MED NETWORKS

Administered by Select Health

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	\$1,000		\$1,500
Out-of-Pocket Maximum	\$4,000		\$5,500
Family Coverage, 2 or more enrolled - per calendar Year			
Deductible - per person/family	\$1,000/\$2,000		\$1,500/\$3,000
Out-of-Pocket Maximum - per person/family	\$4,000/\$8,000		\$5,500/\$11,000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)			
INPATIENT SERVICES	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Medical, Surgical and Hospice ⁴	20% after Deductible	20% after Deductible	30% after Deductible
Hospital Level Care at Home ⁴	20% after Deductible	20% after Deductible	Not Covered
Skilled Nursing Facility ⁴ - Up to 60 days per calendar Year	20% after Deductible	20% after Deductible	30% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational ⁴ Up to 40 days per calendar Year for all therapy types combined	20% after Deductible	20% after Deductible	30% after Deductible
Physician's Fees - (Medical, Surgical, Maternity, Anesthesia)	20% after Deductible	20% 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%	Covered 100%	Not Covered
Specialist/Secondary Care Provider (SCP) ¹	\$35 after Deductible	\$35 after Deductible	30% after Deductible
Salt Lake County HealthyMe Medical Clinic	\$10	\$10	Not Covered
Allergy Tests	See Office Visits Above	See Office Visits Above	30% after Deductible
Allergy Treatment and Serum	20% after Deductible	20% after Deductible	30% after Deductible
Major Surgery	20% after Deductible	20% after Deductible	30% after Deductible
Physician's Fees - (Medical, Surgical, Maternity, Anesthesia)	20% after Deductible	20% 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 SERVICES⁴	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Outpatient Facility	20% after Deductible	20% after Deductible	30% after Deductible
Ambulatory Surgical Center	20% after Deductible	20% after Deductible	30% after Deductible
Imaging Center	20% after Deductible	20% after Deductible	30% after Deductible
Ambulance (Air or Ground) - Emergencies Only	20% 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 [®]	\$25 after Deductible	\$25 after Deductible	Not Available
Radiation	20% after Deductible	20% after Deductible	30% after Deductible
Dialysis	20% after Deductible	20% after Deductible	30% after Deductible
Diagnostic Tests: Minor ²	Covered 100% after Deductible	Covered 100% after Deductible	30% after Deductible
Diagnostic Tests: Major ²	20% after Deductible	20% after Deductible	30% after Deductible
Home Health, Hospice, Outpatient Private Nurse Up to 60 visits per calendar Year	Covered 100% after Deductible	Covered 100% after Deductible	30% after Deductible
Outpatient Cardiac Rehab	Covered 100%	Covered 100%	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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	TIER 1 VALUE	TIER 2 MED	OUT-OF- NETWORK
MISCELLANEOUS SERVICES	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment (DME) ⁴	20% after Deductible	20% after Deductible	30% after Deductible
Miscellaneous Medical Supplies (MMS) ³	20% after Deductible	20% after Deductible	30% after Deductible
Autism Spectrum Disorder	20% after Deductible	20% 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 - <i>Select Services</i>	50% after Deductible	50% after Deductible	50% after Deductible
TMJ (Temporomandibular Joint) Services - <i>Up to \$2,000 lifetime</i>	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%	Covered 100%	30% after Deductible
Inpatient	20% after Deductible	20% after Deductible	30% after Deductible
Outpatient	20% after Deductible	20% after Deductible	30% after Deductible
Residential Treatment ²	20% after Deductible	20% 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/Assisted Reproductive Technology (ART) ^{4,7}	Covered 100% after In-Network Deductible, up to \$4,000 reimbursement limit		
Healthcare Provider Administered Injectable or Infusible Drugs ⁴	20% after Deductible	20% after Deductible	30% after Deductible
Bariatric Surgery (<i>Up to one surgery/lifetime</i>) ⁴	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	Not Covered
PRESCRIPTION DRUGS			
Prescription Drug List (formulary)	RxSelect [®]		
Prescription Drugs - <i>Up to 30 Day Supply of Covered Medications</i> ⁴			
Tier 1	\$10		
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 (<i>Must be filled at Intermountain Specialty Pharmacy</i>)	20% with a maximum of \$150 after In-Network Deductible		
Maintenance Drugs - <i>90 Day Supply (Mail-Order, Retail90[®])-selected drugs</i> ⁴			
Tier 1	\$20		
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		
Generic Substitution Required	Generic required or must pay Copay plus cost difference between name brand and generic		

1 Refer to selecthealth.org/find-care 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 Up to \$4,000 per adoption or up to \$4,000 per single-embryo ART implant. Excludes multiple-embryo ART implants.

* 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.