SALT LAKE COUNTY — OPTION 3 — 01/01/2026

Select Health

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 SERVICES[4]	**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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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]	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 - *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%	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 *(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		
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		
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.