

This is a Gold plan as defined by the Affordable Care Act



	IN-NETWORK
	You must use In-Network Providers (except for emergencies)
DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM^{4,5}	IN-NETWORK
Self Only Coverage, 1 person enrolled - per calendar Year	
Deductible	\$0
Out-of-Pocket Maximum	\$6,500
Family Coverage, 2 or more enrolled - per calendar Year	
Deductible - per person/family	\$0/\$0
Out-of-Pocket Maximum - per person/family	\$6,500/\$13,000
<i>This amount is your Deductible + your Coinsurance and Copay (medical and Rx)</i>	
INPATIENT SERVICES³	IN-NETWORK
Medical, Surgical, Hospice, Emergency Admissions <i>Up to a 3 day Copay maximum</i>	\$600 per day
Skilled Nursing Facility <i>Up to 60 days/calendar Year; Up to a 3 day Copay maximum</i>	\$600 per day
Rehab Therapy: Physical, Speech, Occupational <i>Up to 40 days/calendar Year for all therapy types combined; Up to a 3 day Copay maximum</i>	\$50 per day
Physician's Fees – Medical, Surgical, Maternity, Anesthesia	Covered 100%
PROFESSIONAL SERVICES³	IN-NETWORK
Office Visits and Office Surgeries	
Primary Care Provider (PCP) ¹	\$25
Primary Care Provider (PCP) Virtual Visits ¹	Covered 100%
Secondary Care Provider (SCP) ¹	\$50
Allergy Tests	See office visits
Allergy Treatment and Serum	\$50
Physician's Fees – Surgical	\$50
Physician's Fees – Medical, Maternity, Anesthesia	Covered 100%
PREVENTIVE SERVICES AS OUTLINED BY THE ACA²	IN-NETWORK
Office Visits (PCP/SCP) ¹	Covered 100%
Adult and Pediatric Immunizations	Covered 100%
Diagnostic Tests: Minor	Covered 100%
Other Preventive Services	Covered 100%
VISION SERVICES	IN-NETWORK
Pediatric Preventive Eye Exams - Through Age 18 Years, Only ²	Covered 100%
Adult Preventive Eye Exams - Age 19 and Over ²	Covered 100%
All Other Eye Exams - Adult/Pediatric	\$50
Contacts and Corrective Lenses - Through Age 18 Years, Only <i>Limit one pair of eyeglass lenses or contact lenses per Year</i>	\$50
OUTPATIENT SERVICES	IN-NETWORK
Outpatient Facility and Ambulatory Surgical	\$500
Ambulance (Air or Ground) – emergencies only	\$250
Emergency Room In-Network Facility	\$750
Emergency Room Out-of-Network Facility	\$750
Intermountain InstaCare [®] Facilities, Urgent Care Facilities	\$40
Intermountain KidsCare [®] Facilities	\$25
Intermountain Connect Care [®]	Covered 100%
Radiation	20%
Dialysis	\$50
Diagnostic Tests: Minor, per Provider	Covered 100%
Diagnostic Tests: Major, per Provider	\$200
Home Health ³	\$50
Hospice ³	\$50
Outpatient Cardiac Rehab	Covered 100%
Outpatient Private Nurse ³	\$50
Outpatient Rehab Therapy: Physical, Speech, Occupational <i>Up to 20 visits/calendar Year for all therapy types combined</i>	\$50
Outpatient Habilitative Therapy: Physical, Speech, Occupational <i>Up to 20 visits/calendar Year for all therapy types combined</i>	\$50

MISCELLANEOUS SERVICES	IN-NETWORK
Maternity and Adoption ^{3,6} <i>Includes all related maternity and adoption services. Enroll in SelectHealth Healthy Beginnings Program[®]: 866-442-5052</i>	See Professional, Inpatient, or Outpatient Services
Chiropractic Care <i>Up to 10 visits/calendar Year</i>	\$25
Miscellaneous Medical Supplies (MMS) ²	\$500
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Durable Medical Equipment (DME) ³	20%
Prosthetic Devices ³	20%
Injectable Drugs, Chemotherapy, and Specialty Medications ³	30% after Deductible
Infertility (<i>select services only</i>)	50%
Pediatric Dental, SelectHealth Classic Network (<i>through 18 Years</i>) <i>Oral examinations and cleanings - two per calendar Year</i>	\$50
Mental Health and Chemical Dependency ³	
Office Visits	\$25
Virtual Visits	Covered 100%
Inpatient - Up to a 3 day Copay maximum	\$600 per day
Outpatient	\$250
Residential Treatment Center - Up to a 3 day Copay maximum	\$600 per day
Cochlear Implants, Hearing Aids, or Auditory Osseointegrated Devices ³ <i>One device every 36 months per ear</i>	See Professional, Inpatient, or Outpatient Services
Donor Fees for Organ Transplants ³	See Professional, Inpatient, or Outpatient Services
TMJ (Temporomandibular Joint) Services <i>Up to \$2,000/lifetime</i>	See Professional, Inpatient, or Outpatient Services

PRESCRIPTION DRUGS ³	
Prescription Drug List (formulary)	RxSelect [®]
Prescription Drug Deductible - <i>Per Person</i>	None
Out-of-Pocket Maximum	Combined with medical
Prescription Drugs – <i>Up to a 30-day supply for covered medications</i>	
Tier 1	\$10
Tier 2	\$20
Tier 3	\$75
Tier 4	50%
Tier 5	30%
Maintenance Drugs – <i>90-day supply (Mail-Order, Retail90[®])</i>	
Tier 1	\$10
Tier 2	\$20
Tier 3	\$225
Tier 4	50%
Generic Substitution Required	Generic required or must pay Copay plus cost difference between name brand and generic

FOOTNOTES

1. Visit selecthealth.org/findadoctor to find out whether a Provider is a Primary Care or Secondary Care Provider.

2. Frequency and/or quantity limitations apply to some preventive care and MMS services.

3. 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.

4. All Deductible/Copay/Coinsurance amounts are based on the allowed amounts and not on the Providers billed charges. Out-of-Network Providers or Facilities have not agreed to accept the allowed amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services, sometimes referred to as balance billing. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

5. Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.

6. SelectHealth provides a \$4,000 adoption indemnity benefit as outlined by the state of Utah. Deductible, Copay, or Coinsurance listed under the maternity benefit applies and may exhaust the benefits prior to any plan payment.

For more information, refer to your Certificate of Coverage or Contract or call Member Services at 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.