SMALL EMPLOYER MEMBER PAYMENT SUMMARY (MPS) 1/1/2022 S30C3161

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

selecthealth MED NETWORK

	IN-NETWORK 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.
DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM[4,5]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar Year		
Deductible	$500	$3,000
Out-of-Pocket Maximum	$4,000	$20,000
Family Coverage, 2 or more enrolled - per calendar Year		
Deductible - per person/family	$500/$1,500	$3,000/$9,000
Out-of-Pocket Maximum - per person/family	$4,000/$8,000	$20,000/$40,000
This amount is your Deductible + your Coinsurance and Copay (medical and Rx)		
INPATIENT SERVICES[3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical, Hospice, Emergency Admissions	20% after Deductible	50% after Deductible
Skilled Nursing Facility *Up to 60 days/calendar Year*	20% after Deductible	50% after Deductible
Rehab Therapy: Physical, Speech, Occupational *Up to 40 days/calendar Year for all therapy types combined*	$35 after Deductible	50% after Deductible
Physician's Fees - *Medical, Surgical, Maternity, Anesthesia*	20% after Deductible	50% after Deductible
PROFESSIONAL SERVICES[3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits and Office Surgeries		
Primary Care Provider (PCP)[1]	$15	50% after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100%	Not Covered
Secondary Care Provider (SCP)[1]	$35	50% after Deductible
Allergy Tests	See office visits	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Physician's Fees - *Surgical*	20% after Deductible	50% after Deductible
Physician's Fees - *Medical, Maternity, Anesthesia*	20% after Deductible	50% after Deductible
PREVENTIVE CARE AS OUTLINED BY THE ACA[2]	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits (PCP/SCP)[1]	Covered 100%	Not Covered
Adult and Pediatric Immunizations	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**
Pediatric Preventive Eye Exams - Through Age 18 Years, Only[2]	Covered 100%	Not Covered
Adult Preventive Eye Exams - Age 19 and Over[2]	Covered 100%	Not Covered
All Other Eye Exams - Adult/Pediatric	$35	50% after Deductible
Contacts and Corrective Lenses - Through Age 18 Years, Only *Limit one pair of eyeglass lenses or contact lenses per Year*	20% after Deductible	50% after Deductible
OUTPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility and Ambulatory Surgical	20% after Deductible	50% after Deductible
Ambulance (Air or Ground) - *emergencies only*	20% after Deductible	See In-Network Benefit
Emergency Room In-Network Facility	$350 after Deductible	See In-Network Benefit
Emergency Room Out-of-Network Facility	$350 after Deductible	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$35	50% after Deductible
Intermountain KidsCare® Facilities	$15	Not Available
Intermountain Connect Care®	Covered 100%	Not Available
Radiation	20% after Deductible	50% after Deductible
Dialysis	20% after Deductible	50% after Deductible
Diagnostic Tests: Minor, per Provider	Covered 100%	50% after Deductible
Diagnostic Tests: Major, per Provider	20% after Deductible	50% after Deductible
Home Health[3]	20% after Deductible	50% after Deductible
Hospice[3]	20% after Deductible	50% after Deductible
Outpatient Cardiac Rehab	Covered 100%	50% after Deductible
Outpatient Private Nurse[3]	20% after Deductible	50% after Deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational *Up to 20 visits/calendar Year for all therapy types combined*	$35	50% after Deductible
Outpatient Habilitative Therapy: Physical, Speech, Occupational *Up to 20 visits/calendar Year for all therapy types combined*	$35	50% after Deductible

See next page for additional benefits and footnotes.

MISCELLANEOUS SERVICES	IN-NETWORK	OUT-OF-NETWORK
Maternity and Adoption[3,6] *Includes all related maternity and adoption services. Enroll in SelectHealth Healthy Beginnings Program® : 866-442-5052*	See Professional, Inpatient, or Outpatient Services	See Professional, Inpatient, or Outpatient Services
Chiropractic Care *Up to 10 visits/calendar Year*	$15	50% after Deductible
Miscellaneous Medical Supplies (MMS)[2]	20% 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
Durable Medical Equipment (DME)[3]	20% after Deductible	50% after Deductible
Prosthetic Devices[3]	20% after Deductible	50% after Deductible
Injectable Drugs, Chemotherapy, and Specialty Medications[3]	30% after Deductible	50% after Deductible
Infertility *(select services only)*	50% after Deductible	Not Covered
Pediatric Dental, SelectHealth Classic Network *(through 18 Years)* *Oral examinations and cleanings - two per calendar Year*	$35	Not Covered
Mental Health and Chemical Dependency[3]		
Office Visits	$15	50% after Deductible
Virtual Visits	Covered 100%	50% after Deductible
Inpatient	20% after Deductible	50% after Deductible
Outpatient	20% after Deductible	50% after Deductible
Residential Treatment Center	20% after Deductible	50% after Deductible
Cochlear Implants, Hearing Aids, or Auditory Osseointegrated Devices[3] *One device every 36 months per ear*	See Professional, Inpatient, or Outpatient Services	Not Covered
Donor Fees for Organ Transplants[3]	See Professional, Inpatient, or Outpatient Services	Not Covered
TMJ (Temporomandibular Joint) Services *Up to $2,000/lifetime*	See Professional, Inpatient, or Outpatient Services	Not Covered

PRESCRIPTION DRUGS[3]	
Prescription Drug List (formulary)	RxSelect®
Prescription Drug Deductible - *Per Person*	None
Out-of-Pocket Maximum	Combined with medical
Prescription Drugs – *Up to 30-day supply for covered medications*	
Tier 1	$5
Tier 2	$15
Tier 3	25%
Tier 4	50%
Tier 5	30%
Maintenance Drugs – *90-day supply (Mail-Order, Retail90®)*	
Tier 1	$5
Tier 2	$15
Tier 3	25%
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 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.
All Covered Services obtained outside the United States, except for routine, Urgent, or Emergency conditions require preauthorization.
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.