# SMALL EMPLOYER MEMBER PAYMENT SUMMARY (MPS) 1/1/2022 S30C3141

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

selecthealth MED NETWORK

| | IN-NETWORK<br>When using In-Network Providers, you are responsible to pay the amounts in this column. | OUT-OF-NETWORK<br>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 | $2,800 | $5,600 |
| Out-of-Pocket Maximum | $7,900 | $20,000 |
| Family Coverage, 2 or more enrolled - per calendar Year | | |
| Deductible - per person/family | $2,800/$5,600 | $5,600/$11,200 |
| Out-of-Pocket Maximum - per person/family | $7,900/$15,800 | $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 | 40% after Deductible | 50% after Deductible |
| Skilled Nursing Facility<br>*Up to 60 days/calendar Year* | 40% after Deductible | 50% after Deductible |
| Rehab Therapy: Physical, Speech, Occupational<br>*Up to 40 days/calendar Year for all therapy types combined* | $50 after Deductible | 50% after Deductible |
| Physician's Fees - *Medical, Surgical, Maternity, Anesthesia* | 40% after Deductible | 50% after Deductible |
| **PROFESSIONAL SERVICES[3]** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| Office Visits and Office Surgeries | | |
| Primary Care Provider (PCP)[1] | $25 | 50% after Deductible |
| Primary Care Provider (PCP) Virtual Visits[1] | Covered 100% | Not Covered |
| Secondary Care Provider (SCP)[1] | $50 | 50% after Deductible |
| Allergy Tests | See office visits | Not Covered |
| Allergy Treatment and Serum | 40% | Not Covered |
| Physician's Fees - *Surgical* | 40% after Deductible | 50% after Deductible |
| Physician's Fees - *Medical, Maternity, Anesthesia* | 40% 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 | $50 | 50% after Deductible |
| Contacts and Corrective Lenses - Through Age 18 Years, Only<br>*Limit one pair of eyeglass lenses or contact lenses per Year* | 40% after Deductible | 50% after Deductible |
| **OUTPATIENT SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| Outpatient Facility and Ambulatory Surgical | 40% after Deductible | 50% after Deductible |
| Ambulance (Air or Ground) - *emergencies only* | 40% 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 | $50 | 50% after Deductible |
| Intermountain KidsCare® Facilities | $25 | Not Available |
| Intermountain Connect Care® | Covered 100% | Not Available |
| Radiation | 40% after Deductible | 50% after Deductible |
| Dialysis | 40% after Deductible | 50% after Deductible |
| Diagnostic Tests: Minor, per Provider | Covered 100% after Deductible | 50% after Deductible |
| Diagnostic Tests: Major, per Provider | 40% after Deductible | 50% after Deductible |
| Home Health[3] | 40% after Deductible | 50% after Deductible |
| Hospice[3] | 40% after Deductible | 50% after Deductible |
| Outpatient Cardiac Rehab | Covered 100% | 50% after Deductible |
| Outpatient Private Nurse[3] | 40% after Deductible | 50% after Deductible |
| Outpatient Rehab Therapy: Physical, Speech, Occupational<br>*Up to 20 visits/calendar Year for all therapy types combined* | $50 | 50% after Deductible |
| Outpatient Habilitative Therapy: Physical, Speech, Occupational<br>*Up to 20 visits/calendar Year for all therapy types combined* | $50 | 50% after Deductible |



*See next page for additional benefits and footnotes.*

| MISCELLANEOUS SERVICES | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| Maternity and Adoption[3,6]<br>*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<br>*Up to 10 visits/calendar Year* | $20 | 50% after Deductible |
| Miscellaneous Medical Supplies (MMS)[2] | 40% 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] | 40% after Deductible | 50% after Deductible |
| Prosthetic Devices[3] | 40% after Deductible | 50% after Deductible |
| Injectable Drugs, Chemotherapy, and Specialty Medications[3] | 50% after Deductible | 50% after Deductible |
| Infertility *(select services only)* | 50% after Deductible | Not Covered |
| Pediatric Dental, SelectHealth Classic Network *(through 18 Years)*<br>*Oral examinations and cleanings - two per calendar Year* | $50 | Not Covered |
| Mental Health and Chemical Dependency[3] | | |
| Office Visits | $25 | 50% after Deductible |
| Virtual Visits | Covered 100% | 50% after Deductible |
| Inpatient | 40% after Deductible | 50% after Deductible |
| Outpatient | 40% after Deductible | 50% after Deductible |
| Residential Treatment Center | 40% after Deductible | 50% after Deductible |
| Cochlear Implants, Hearing Aids, or Auditory Osseointegrated Devices[3]<br>*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<br>*Up to $2,000/lifetime* | See Professional, Inpatient, or Outpatient Services | Not Covered |

| PRESCRIPTION DRUGS[3] | |
|---|---|
| Prescription Drug List (formulary) | RxSelect®<br>Individual/Family |
| Prescription Drug Deductible | $500/$1,000 |
| Out-of-Pocket Maximum | Combined with medical |
| Prescription Drugs – *Up to 30-day supply for covered medications* | |
| Tier 1 | $20 |
| Tier 2 | $30 |
| Tier 3 | 25% after pharmacy Deductible |
| Tier 4 | 50% after pharmacy Deductible |
| Tier 5 | 50% after pharmacy Deductible |
| Maintenance Drugs – *90-day supply (Mail-Order, Retail90®)* | |
| Tier 1 | $20 |
| Tier 2 | $30 |
| Tier 3 | 25% after pharmacy Deductible |
| Tier 4 | 50% after pharmacy Deductible |
| 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.*