# SMALL EMPLOYER MEMBER PAYMENT SUMMARY (MPS) 1/1/2022 S30C3157

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

selecthealth

MED NETWORK/HSA QUALIFIED

| | 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 | $4,500 | $10,000 |
| Out-of-Pocket Maximum | $4,500 | $10,000 |
| Family Coverage, 2 or more enrolled - per calendar Year | | |
| Deductible - per person/family | $4,500/$9,000 | $10,000/$20,000 |
| Out-of-Pocket Maximum - per person/family | $4,500/$9,000 | $10,000/$20,000 |
| *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 | Covered 100% after Deductible | Covered 100% after Deductible |
| Skilled Nursing Facility<br>*Up to 60 days/calendar Year* | Covered 100% after Deductible | Covered 100% after Deductible |
| Rehab Therapy: Physical, Speech, Occupational<br>*Up to 40 days/calendar Year for all therapy types combined* | Covered 100% after Deductible | Covered 100% after Deductible |
| Physician's Fees - *Medical, Surgical, Maternity, Anesthesia* | Covered 100% after Deductible | Covered 100% after Deductible |
| **PROFESSIONAL SERVICES[3]** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| Office Visits and Office Surgeries | | |
| Primary Care Provider (PCP)[1] | Covered 100% after Deductible | Covered 100% after Deductible |
| Primary Care Provider (PCP) Virtual Visits[1] | Covered 100% after deductible | Not Covered |
| Secondary Care Provider (SCP)[1] | Covered 100% after Deductible | Covered 100% after Deductible |
| Allergy Tests | See office visits | Not Covered |
| Allergy Treatment and Serum | Covered 100% after Deductible | Not Covered |
| Physician's Fees - *Surgical* | Covered 100% after Deductible | Covered 100% after Deductible |
| Physician's Fees - *Medical, Maternity, Anesthesia* | Covered 100% after Deductible | Covered 100% 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 | Covered 100% after Deductible | Covered 100% after Deductible |
| Contacts and Corrective Lenses - Through Age 18 Years, Only<br>*Limit one pair of eyeglass lenses or contact lenses per Year* | Covered 100% after Deductible | Covered 100% after Deductible |
| **OUTPATIENT SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| Outpatient Facility and Ambulatory Surgical | Covered 100% after Deductible | Covered 100% after Deductible |
| Ambulance (Air or Ground) - *emergencies only* | Covered 100% after Deductible | See In-Network Benefit |
| Emergency Room In-Network Facility | Covered 100% after Deductible | See In-Network Benefit |
| Emergency Room Out-of-Network Facility | Covered 100% after Deductible | See In-Network Benefit |
| Intermountain InstaCare® Facilities, Urgent Care Facilities | Covered 100% after Deductible | Covered 100% after Deductible |
| Intermountain KidsCare® Facilities | Covered 100% after Deductible | Not Available |
| Intermountain Connect Care® | Covered 100% after deductible | Not Available |
| Radiation | Covered 100% after Deductible | Covered 100% after Deductible |
| Dialysis | Covered 100% after Deductible | Covered 100% after Deductible |
| Diagnostic Tests: Minor, per Provider | Covered 100% after Deductible | Covered 100% after Deductible |
| Diagnostic Tests: Major, per Provider | Covered 100% after Deductible | Covered 100% after Deductible |
| Home Health[3] | Covered 100% after Deductible | Covered 100% after Deductible |
| Hospice[3] | Covered 100% after Deductible | Covered 100% after Deductible |
| Outpatient Cardiac Rehab | Covered 100% after Deductible | Covered 100% after Deductible |
| Outpatient Private Nurse[3] | Covered 100% after Deductible | Covered 100% after Deductible |
| Outpatient Rehab Therapy: Physical, Speech, Occupational<br>*Up to 20 visits/calendar Year for all therapy types combined* | Covered 100% after Deductible | Covered 100% after Deductible |
| Outpatient Habilitative Therapy: Physical, Speech, Occupational<br>*Up to 20 visits/calendar Year for all therapy types combined* | Covered 100% after Deductible | Covered 100% 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* | Covered 100% after Deductible | Covered 100% after Deductible |
| Miscellaneous Medical Supplies (MMS)[2] | Covered 100% after Deductible | Covered 100% 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] | Covered 100% after Deductible | Covered 100% after Deductible |
| Prosthetic Devices[3] | Covered 100% after Deductible | Covered 100% after Deductible |
| Injectable Drugs, Chemotherapy, and Specialty Medications[3] | Covered 100% after Deductible | Covered 100% after Deductible |
| Infertility *(select services only)* | Covered 100% after Deductible | Not Covered |
| Pediatric Dental, SelectHealth Classic Network *(through 18 Years)*<br>*Oral examinations and cleanings - two per calendar Year* | Covered 100% after Deductible | Not Covered |
| Mental Health and Chemical Dependency[3] | | |
| Office Visits | Covered 100% after Deductible | Covered 100% after Deductible |
| Virtual Visits | Covered 100% after deductible | Covered 100% after Deductible |
| Inpatient | Covered 100% after Deductible | Covered 100% after Deductible |
| Outpatient | Covered 100% after Deductible | Covered 100% after Deductible |
| Residential Treatment Center | Covered 100% after Deductible | Covered 100% 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® | |
| Prescription Drugs – *Up to 30-day supply for covered medications* | | |
| Tier 1 | Covered 100% after Deductible | |
| Tier 2 | Covered 100% after Deductible | |
| Tier 3 | Covered 100% after Deductible | |
| Tier 4 | Covered 100% after Deductible | |
| Tier 5 | Covered 100% after Deductible | |
| Maintenance Drugs – *90-day supply (Mail-Order, Retail90® )* | | |
| Tier 1 | Covered 100% after Deductible | |
| Tier 2 | Covered 100% after Deductible | |
| Tier 3 | Covered 100% after Deductible | |
| Tier 4 | Covered 100% after Deductible | |
| Deductible Waiver | Certain prescription drugs are not subject to the 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.*