SMALL EMPLOYER MEMBER PAYMENT SUMMARY (MPS)	1/1/2022	S40A3028

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

selecthealth

VALUE NETWORK/HSA QUALIFIED

	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	$1,750
Out-of-Pocket Maximum	$7,000
Family Coverage, 2 or more enrolled - per calendar Year	
Deductible	$3,500
Out-of-Pocket Maximum - per person/family	$7,000/$14,000
This amount is your Deductible + your Coinsurance and Copay (medical and Rx)	
INPATIENT SERVICES[3]	**IN-NETWORK**
Medical, Surgical, Hospice, Emergency Admissions	40% after Deductible
Skilled Nursing Facility	40% after Deductible
Up to 60 days/calendar Year	
Rehab Therapy: Physical, Speech, Occupational	$50 after Deductible
Up to 40 days/calendar Year for all therapy types combined	
Physician's Fees – *Medical, Surgical, Maternity, Anesthesia*	40% after Deductible
PROFESSIONAL SERVICES[3]	**IN-NETWORK**
Office Visits and Office Surgeries	
Primary Care Provider (PCP)[1]	$30 after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100% after deductible
Secondary Care Provider (SCP)[1]	$50 after Deductible
Allergy Tests	See office visits
Allergy Treatment and Serum	40% after Deductible
Physician's Fees – *Surgical*	40% after Deductible
Physician's Fees – *Medical, Maternity, Anesthesia*	40% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2]	**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 after Deductible
Contacts and Corrective Lenses - Through Age 18 Years, Only	40% after Deductible
Limit one pair of eyeglass lenses or contact lenses per Year	
OUTPATIENT SERVICES	**IN-NETWORK**
Outpatient Facility and Ambulatory Surgical	40% after Deductible
Ambulance (Air or Ground) – *emergencies only*	40% after Deductible
Emergency Room In-Network Facility	$350 after Deductible
Emergency Room Out-of-Network Facility	$350 after Deductible
Intermountain InstaCare® Facilities, Urgent Care Facilities	$50 after Deductible
Intermountain KidsCare® Facilities	$30 after Deductible
Intermountain Connect Care®	Covered 100% after deductible
Radiation	40% after Deductible
Dialysis	40% after Deductible
Diagnostic Tests: Minor, per Provider	Covered 100% after Deductible
Diagnostic Tests: Major, per Provider	40% after Deductible
Home Health[3]	40% after Deductible
Hospice[3]	40% after Deductible
Outpatient Cardiac Rehab	Covered 100% after Deductible
Outpatient Private Nurse[3]	40% after Deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational	$50 after Deductible
Up to 20 visits/calendar Year for all therapy types combined	
Outpatient Habilitative Therapy: Physical, Speech, Occupational	$50 after Deductible
Up to 20 visits/calendar Year for all therapy types combined	

See next page for additional benefits and footnotes.

MISCELLANEOUS SERVICES	IN-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
Chiropractic Care *Up to 10 visits/calendar Year*	$20 after Deductible
Miscellaneous Medical Supplies (MMS)[2]	40% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Durable Medical Equipment (DME)[3]	40% after Deductible
Prosthetic Devices[3]	40% after Deductible
Injectable Drugs, Chemotherapy, and Specialty Medications[3]	50% after Deductible
Infertility (s*elect services only)*	50% after Deductible
Pediatric Dental, SelectHealth Classic Network *(through 18 Years)* *Oral examinations and cleanings - two per calendar Year*	$50 after Deductible
Mental Health and Chemical Dependency[3]	
Office Visits	$30 after Deductible
Virtual Visits	Covered 100% after deductible
Inpatient	40% after Deductible
Outpatient	40% after Deductible
Residential Treatment Center	40% after Deductible
Cochlear Implants, Hearing Aids, or Auditory Osseointegrated Devices[3] *One device every 36 months per ear*	See Professional, Inpatient, or Outpatient Services
Donor Fees for Organ Transplants[3]	See Professional, Inpatient, or Outpatient Services
TMJ (Temporomandibular Joint) Services *Up to $2,000/lifetime*	See Professional, Inpatient, or Outpatient Services
PRESCRIPTION DRUGS[3]	
Prescription Drug List (formulary)	RxSelect®
Prescription Drugs – *Up to a 30-day supply for covered medications*	
Tier 1	$20 after Deductible
Tier 2	$30 after Deductible
Tier 3	25% after Deductible
Tier 4	50% after Deductible
Tier 5	50% after Deductible
Maintenance Drugs – *90-day supply (Mail-Order, Retail90®)*	
Tier 1	$20 after Deductible
Tier 2	$30 after Deductible
Tier 3	25% after Deductible
Tier 4	50% 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 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.