INDIVIDUAL MEMBER PAYMENT SUMMARY (MPS) BENCHMARK 01/01/2024 I40A2007

Value Benchmark Silver 3750 Deductible - HSA Qualified

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

Select Health

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	$3,750
Out-of-Pocket Maximum	$7,500
Family Coverage, 2 or more enrolled - per calendar Year	
Deductible	$7,500
Out-of-Pocket Maximum - per person/family	$7,500/$15,000
This amount is your Deductible + your Coinsurance and Copay (medical and Rx)	
INPATIENT SERVICES[3]	**IN-NETWORK**
Medical, Surgical, Hospice, Emergency Admissions	20% after Deductible
Hospital level care at home	20% after Deductible
Skilled Nursing Facility	20% after Deductible
Up to 30 days/calendar Year	
Rehab Therapy: Physical, Speech, Occupational	Covered 100% after Deductible
Up to 30 days/calendar Year for all therapy types combined	
Physician's Fees – *Medical, Surgical, Maternity, Anesthesia*	20% after Deductible
PROFESSIONAL SERVICES[3]	**IN-NETWORK**
Office Visits and Office Surgeries	
Primary Care Provider (PCP)[1]	Covered 100% after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100%
Specialist/Secondary Care Provider (SCP)[1]	Covered 100% after Deductible
Allergy Tests	See office visits
Allergy Treatment and Serum	20% after Deductible
Physician's Fees – *Surgical*	20% after Deductible
Physician's Fees – *Medical, Maternity, Anesthesia*	20% 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]	Not Covered
All Other Eye Exams - Adult/Pediatric	Covered 100% after Deductible
Contacts and Corrective Lenses - Through Age 18 Years, Only	Covered 100% after Deductible
Limit one pair of eyeglass lenses or contact lenses per Year	
OUTPATIENT SERVICES	**IN-NETWORK**
Outpatient Facility	20% after Deductible
Ambulatory Surgical Center	10% after Deductible
Imaging Center	$100 after Deductible
Ambulance (Air or Ground) – *emergencies only*	20% after Deductible
Emergency Room	20% after Deductible
Intermountain InstaCare® Facilities, Urgent Care Facilities	Covered 100% after Deductible
Intermountain KidsCare® Facilities	Covered 100% after Deductible
Intermountain Connect Care®	Covered 100%
Radiation	Covered 100% after Deductible
Dialysis	Covered 100% after Deductible
Diagnostic Tests: Minor, per Provider	Covered 100% after Deductible
Diagnostic Tests: Major, per Provider	20% after Deductible
Home Health[3]	Covered 100% after Deductible
Up to 30 visits/calendar Year	
Hospice[3]	Covered 100% after Deductible
Up to 6 months every 3 Years	
Outpatient Cardiac Rehab	Covered 100% after Deductible
Outpatient Private Nurse	Not Covered
Outpatient Rehab Therapy: Physical, Speech, Occupational	Covered 100% after Deductible
Up to 20 visits/calendar Year for all therapy types combined	
Outpatient Habilitative Therapy: Physical, Speech, Occupational	Covered 100% after Deductible
Up to 20 visits/calendar Year for all therapy types combined	

See next page for additional benefits and footnotes.

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MISCELLANEOUS SERVICES	**IN-NETWORK**
Maternity and Adoption[3,6]	See Professional, Inpatient, or Outpatient Services
Includes all related maternity and adoption services. Enroll in SelectHealth Healthy Beginnings Program® : 866-442-5052	
Chiropractic Care	Not Covered
Miscellaneous Medical Supplies (MMS)[2]	Covered 100% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Durable Medical Equipment (DME)[3]	Covered 100% after Deductible
Prosthetic Devices[3]	Not Covered
Injectable Drugs and Specialty Medications[3]	50% after Deductible
Chemotherapy[3]	50% after Deductible
Infertility (*select services only)*	50% after Deductible
Mental Health and Chemical Dependency[3]	
Office Visits	Covered 100% after Deductible
Virtual Visits	Covered 100%
Inpatient	20% after Deductible
Outpatient	Covered 100% after Deductible
Residential Treatment Center	20% after Deductible
Cochlear Implants[3]	See Professional, Inpatient, or Outpatient Services
TMJ (Temporomandibular Joint) Services	Not Covered
PRESCRIPTION DRUGS[3]	
Prescription Drug List (formulary)	RxCore®
Prescription Drugs – *Up to a 30-day supply for covered medications*	
Tier 1	Covered 100% after Deductible
Tier 2	Covered 100% after Deductible
Tier 3	20% after Deductible
Tier 4	50% after Deductible
Tier 5	50% after Deductible
Maintenance Drugs – *90-day supply*	
Tier 1 - *Mail-Order, Retail90®*	Covered 100% after Deductible
Tier 2 - *Mail-Order, Retail90®*	Covered 100% after Deductible
Tier 3 - *Intermountain Home Delivery Pharmacy*	20% after Deductible
Tier 4 - *Intermountain Home Delivery Pharmacy*	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 Amount and not on billed charges. Out-of-Network Providers or Facilities may not accept the Allowed Amount for Covered Services. When this occurs, you may be responsible for Excess Charges.**
5. Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.
6. Select Health 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.
7. Select Health will cover an insulin from each therapeutic category with a cap of $28 per prescription of a 30-day supply.

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.