

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

**MED NETWORK****IN-NETWORK**

You must use In-Network Providers (except for emergencies)

**DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM<sup>4,5</sup>****IN-NETWORK**

Self Only Coverage, 1 person enrolled - per calendar Year

Deductible

\$8,550

Out-of-Pocket Maximum

\$8,550

Family Coverage, 2 or more enrolled - per calendar Year

Deductible - per person/family

\$8,550/\$17,100

Out-of-Pocket Maximum - per person/family

\$8,550/\$17,100

*This amount is your Deductible + your Coinsurance and Copay (medical and Rx)***INPATIENT SERVICES<sup>3</sup>****IN-NETWORK**

Medical, Surgical, Hospice, Emergency Admissions

Covered 100% after Deductible

Skilled Nursing Facility

Covered 100% 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***PROFESSIONAL SERVICES<sup>3</sup>****IN-NETWORK**

Office Visits and Office Surgeries

Primary Care Provider (PCP)<sup>1</sup>

Covered 100% after Deductible

Secondary Care Provider (SCP)<sup>1</sup>

Covered 100% after Deductible

Allergy Tests

See office visits

Allergy Treatment and Serum

Covered 100% after Deductible

Physician's Fees – Medical, Surgical, Maternity, Anesthesia

Covered 100% after Deductible

**PREVENTIVE SERVICES AS OUTLINED BY THE ACA<sup>2</sup>****IN-NETWORK**Office Visits (PCP/SCP)<sup>1</sup>

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<sup>2</sup>

Covered 100%

Adult Preventive Eye Exams - Age 19 and Over<sup>2</sup>

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 and Ambulatory Surgical

Covered 100% after Deductible

Ambulance (Air or Ground) – emergencies only

Covered 100% after Deductible

Emergency Room In-Network Facility

Covered 100% after Deductible

Emergency Room Out-of-Network Facility

Covered 100% after Deductible

Intermountain InstaCare<sup>®</sup> Facilities, Urgent Care Facilities

Covered 100% after Deductible

Intermountain KidsCare<sup>®</sup> Facilities

Covered 100% after Deductible

Intermountain Connect Care<sup>®</sup>

Covered 100%

Radiation and Dialysis

Covered 100% after Deductible

Diagnostic Tests: Minor

Covered 100% after Deductible

Diagnostic Tests: Major

Covered 100% after Deductible

Home Health<sup>3</sup>

Covered 100% after Deductible

*Up to 30 visits/calendar Year*Hospice<sup>3</sup>

Covered 100% after Deductible

*Up to 6 months every 3 Years*

Outpatient Cardiac Rehab

Covered 100%

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*

MISCELLANEOUS SERVICES	IN-NETWORK
Maternity and Adoption <sup>3,6</sup> <i>Includes all related maternity and adoption services. Enroll in SelectHealth Healthy Beginnings Program<sup>®</sup> : 866-442-5052</i> Chiropractic Care Miscellaneous Medical Supplies (MMS) <sup>2</sup> Autism Spectrum Disorder  Durable Medical Equipment (DME) <sup>3</sup> Prosthetic Devices <sup>3</sup> Injectable Drugs, Chemotherapy, and Specialty Medications <sup>3</sup> Infertility ( <i>select services only</i> ) Mental Health and Chemical Dependency <sup>3</sup> Office Visits Inpatient Outpatient Residential Treatment Center Cochlear Implants <sup>3</sup> Donor Fees for Organ Transplants <sup>3</sup> TMJ (Temporomandibular Joint) Services	See Professional, Inpatient, or Outpatient Services  Not Covered Covered 100% after Deductible See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services Covered 100% after Deductible Not Covered Covered 100% after Deductible Covered 100% after Deductible  Covered 100% after Deductible Covered 100% after Deductible Covered 100% after Deductible Covered 100% after Deductible  See Professional, Inpatient, or Outpatient Services See Professional, Inpatient, or Outpatient Services Not Covered
PRESCRIPTION DRUGS <sup>3</sup>	IN-NETWORK
Prescription Drug List (formulary) Prescription Drug Deductible - <i>Per Person</i> Out-of-Pocket Maximum Prescription Drugs – <i>Up to a 30-day supply for covered medications</i> Tier 1 Tier 2 Tier 3 Tier 4 Tier 5 Maintenance Drugs – <i>90-day supply</i> Tier 1 - <i>Mail-Order, Retail90<sup>®</sup></i> Tier 2 - <i>Mail-Order, Retail90<sup>®</sup></i> Tier 3 - <i>Intermountain Home Delivery Pharmacy</i> Tier 4 - <i>Intermountain Home Delivery Pharmacy</i> Generic Substitution Required	RxCore <sup>®</sup> Combined with medical Combined with medical  Covered 100% after Deductible Covered 100% after Deductible Covered 100% after Deductible Covered 100% after Deductible Covered 100% after Deductible  Covered 100% after Deductible Covered 100% after Deductible Covered 100% after Deductible Covered 100% after Deductible  Generic required or must pay Copay plus cost difference between name brand and generic
FOOTNOTES	
<p>1. Visit <a href="https://selecthealth.org/findadoctor">selecthealth.org/findadoctor</a> to find out whether a Provider is a Primary Care or Secondary Care Provider.</p> <p>2. Frequency and/or quantity limitations apply to some preventive care and MMS services.</p> <p>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.</p> <p><b>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.</b></p> <p>5. Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.</p> <p>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.</p> <p><i>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.</i></p>	