

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

**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

\$5,300

Out-of-Pocket Maximum

\$8,550

Family Coverage, 2 or more enrolled - per calendar Year

Deductible - per person/family

\$5,300/\$10,600

Out-of-Pocket Maximum - per person/family

\$8,550/\$17,100

*This amount is your Deductible + your Coinsurance and Copay (medical and Rx)***INPATIENT SERVICES³****IN-NETWORK**

Medical, Surgical, Hospice, Emergency Admissions

\$650 per day after Deductible

Up to a 5 day Copay maximum

Skilled Nursing Facility

\$650 per day after Deductible

Up to 60 days/calendar Year; Up to a 5 day Copay maximum

Rehab Therapy: Physical, Speech, Occupational

\$60 per day after Deductible

*Up to 40 days/calendar Year for all therapy types combined; Up to a 5 day Copay maximum***PROFESSIONAL SERVICES³****IN-NETWORK**

Office Visits and Office Surgeries

Primary Care Provider (PCP)¹

\$35

Secondary Care Provider (SCP)¹

\$60 after Deductible

Allergy Tests

See office visits

Allergy Treatment and Serum

50%

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

50% after Deductible

PREVENTIVE SERVICES AS OUTLINED BY THE ACA²**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, Only²

Covered 100%

Adult Preventive Eye Exams - Age 19 and Over²

Covered 100%

All Other Eye Exams - Adult/Pediatric

\$60 after Deductible

Contacts and Corrective Lenses - Through Age 18 Years, Only

50% after Deductible

*Limit one pair of eyeglass lenses or contact lenses per Year***OUTPATIENT SERVICES****IN-NETWORK**

Outpatient Facility and Ambulatory Surgical

50% after Deductible

Ambulance (Air or Ground) – emergencies only

\$300 after Deductible

Emergency Room In-Network Facility

\$600 after Deductible

Emergency Room Out-of-Network Facility

\$600 after Deductible

Intermountain InstaCare[®] Facilities, Urgent Care Facilities

\$60 after Deductible

*The first Urgent care visit is not subject to the Deductible. Starting with the second visit, the Deductible will apply.*Intermountain KidsCare[®] Facilities

\$35

Intermountain Connect Care[®]

Covered 100%

Radiation and Dialysis

50% after Deductible

Diagnostic Tests: Minor

Covered 100% after Deductible

Diagnostic Tests: Major

\$150 after Deductible

Home Health³

50% after Deductible

Hospice³

50% after Deductible

Outpatient Cardiac Rehab

Covered 100%

Outpatient Private Nurse³

50% after Deductible

Outpatient Rehab Therapy: Physical, Speech, Occupational

\$60

Up to 20 visits/calendar Year for all therapy types combined

Outpatient Habilitative Therapy: Physical, Speech, Occupational

\$60

Up to 20 visits/calendar Year for all therapy types combined

MISCELLANEOUS SERVICES		IN-NETWORK	
Maternity and Adoption ^{3,6} <i>Includes all related maternity and adoption services. Enroll in SelectHealth Healthy Beginnings Program[®] : 866-442-5052</i>		See Professional, Inpatient, or Outpatient Services	
Chiropractic Care		Not Covered	
Miscellaneous Medical Supplies (MMS) ²		50% after Deductible	
Autism Spectrum Disorder		See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services	
Durable Medical Equipment (DME) ³		50% after Deductible	
Prosthetic Devices ³		50% after Deductible	
Injectable Drugs, Chemotherapy, and Specialty Medications ³		30% after Deductible	
Infertility (<i>select services only</i>)		50% after Deductible	
Pediatric Dental, SelectHealth Classic Network (<i>through 18 Years</i>) <i>Oral examinations and cleanings - two per calendar Year</i>		\$60	
Mental Health and Chemical Dependency ³			
Office Visits		\$35	
Inpatient - up to a 5 day Copay maximum		\$650 per day after Deductible	
Outpatient		50% after Deductible	
Residential Treatment Center - up to a 5 day Copay maximum		\$650 per day after Deductible	
Cochlear Implants ³		See Professional, Inpatient, or Outpatient Services	
Donor Fees for Organ Transplants ³		See Professional, Inpatient, or Outpatient Services	
TMJ (Temporomandibular Joint) Services		Not Covered	
PRESCRIPTION DRUGS ³		IN-NETWORK	
Prescription Drug List (formulary)		RxCore [®]	
Prescription Drug Deductible - <i>Per Person</i>		\$2,500	
Out-of-Pocket Maximum		Combined with medical	
Prescription Drugs – <i>Up to a 30-day supply for covered medications</i>			
Tier 1		\$30	
Tier 2		\$40	
Tier 3		\$55 after pharmacy Deductible	
Tier 4		\$70 after pharmacy Deductible	
Tier 5		30% after pharmacy Deductible	
Maintenance Drugs – <i>90-day supply</i>			
Tier 1 - <i>Mail-Order, Retail90[®]</i>		\$30	
Tier 2 - <i>Mail-Order, Retail90[®]</i>		\$40	
Tier 3 - <i>Intermountain Home Delivery Pharmacy</i>		\$165 after pharmacy Deductible	
Tier 4 - <i>Intermountain Home Delivery Pharmacy</i>		\$210 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 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.			