INDIVIDUAL MEMBER PAYMENT SUMMARY (MPS) BENCHMARK 1/1/2021 I40A1650

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

selecthealth.

VALUE NETWORK

	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	$6,800
Out-of-Pocket Maximum	$8,550
Family Coverage, 2 or more enrolled - per calendar Year	
Deductible - per person/family	$6,800/$13,600
Out-of-Pocket Maximum - per person/family	$8,550/$17,100
This amount is your Deductible + your Coinsurance and Copay (medical and Rx)	
INPATIENT SERVICES[3]	**IN-NETWORK**
Medical, Surgical, Hospice, Emergency Admissions	40% after Deductible
Skilled Nursing Facility	40% after Deductible
Up to 30 days/calendar Year	
Rehab Therapy: Physical, Speech, Occupational	$65 after Deductible
Up to 30 days/calendar Year for all therapy types combined	
PROFESSIONAL SERVICES[3]	**IN-NETWORK**
Office Visits and Office Surgeries	
Primary Care Provider (PCP)[1]	$40 after Deductible
Secondary Care Provider (SCP)[1]	$65 after Deductible
Allergy Tests	See office visits
Allergy Treatment and Serum	40% after Deductible
Physician's Fees – *Medical, Surgical, 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]	Not Covered
All Other Eye Exams - Adult/Pediatric	$65 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	$600 after Deductible
Emergency Room Out-of-Network Facility	$600 after Deductible
Intermountain InstaCare® Facilities, Urgent Care Facilities	$65 after Deductible
Intermountain KidsCare® Facilities	$40 after Deductible
Intermountain Connect Care®	Covered 100%
Radiation and Dialysis	40% after Deductible
Diagnostic Tests: Minor	Covered 100% after Deductible
Diagnostic Tests: Major	40% after Deductible
Home Health[3]	40% after Deductible
Up to 30 visits/calendar Year	
Hospice[3]	40% 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	$65
Up to 20 visits/calendar Year for all therapy types combined	
Outpatient Habilitative Therapy: Physical, Speech, Occupational	$65
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]	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]	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]	Not Covered
Injectable Drugs, Chemotherapy, and Specialty Medications[3]	50% after Deductible
Infertility (*select services only)*	50% after Deductible
Pediatric Dental, SelectHealth Classic Network *(through 18 Years)*	$65
Oral examinations and cleanings - two per calendar Year	
Mental Health and Chemical Dependency[3]	
Office Visits	$40 after Deductible
Inpatient	40% after Deductible
Outpatient	40% after Deductible
Residential Treatment Center	40% 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 - *Per Person*	$1,000
Out-of-Pocket Maximum	Combined with medical
Prescription Drugs – *Up to a 30-day supply for covered medications*	
Tier 1	$20
Tier 2	$30
Tier 3	25% after pharmacy Deductible
Tier 4	50% after pharmacy Deductible
Tier 5	50% after pharmacy Deductible
Maintenance Drugs – *90-day supply*	
Tier 1 - *Mail-Order, Retail90®*	$20
Tier 2 - *Mail-Order, Retail90®*	$30
Tier 3 - *Intermountain Home Delivery Pharmacy*	25% after pharmacy Deductible
Tier 4 - *Intermountain Home Delivery Pharmacy*	50% 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.