SMALL EMPLOYER MEMBER PAYMENT SUMMARY (MPS)	1/1/2019	S30C2564

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

MED NETWORK

	PARTICIPATING	NONPARTICIPATING
	In-Network When using participating providers, you are responsible to pay the amounts in this column.	*Out-of-Network* When using nonparticipating providers, you are responsible to pay the amounts in this column.
DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM[4]	**PARTICIPATING**	**NONPARTICIPATING**
Self Only Coverage, 1 person enrolled - per calendar year		
Deductible	$1,000	$3,000
Out-of-Pocket Maximum	$7,350	$20,000
Family Coverage, 2 or more enrolled - per calendar year		
Deductible - per person/family	$1,000/$2,500	$3,000/$9,000
Out-of-Pocket Maximum - per person/family	$7,350/$14,700	$20,000/$40,000
This amount is your deductible + your coinsurance and copay (medical and Rx)		
INPATIENT SERVICES[3]	**PARTICIPATING**	**NONPARTICIPATING**
Medical, Surgical, Hospice, Emergency Admissions	20% after deductible	50% after deductible
Skilled Nursing Facility	20% after deductible	50% after deductible
Up to 60 days/calendar year		
Rehab Therapy: Physical, Speech, Occupational	20% after deductible	50% after deductible
Up to 40 days/calendar year for all therapy types combined		
PROFESSIONAL SERVICES[3]	**PARTICIPATING**	**NONPARTICIPATING**
Office Visits and Office Surgeries		
Primary Care Provider (PCP)[1]	$25	50% after deductible
Secondary Care Provider (SCP)[1]	$40	50% after deductible
Allergy Tests	See office visits	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Physician's Fees - *Medical, Surgical, Maternity, Anesthesia*	20% after deductible	50% after deductible
PREVENTIVE CARE AS OUTLINED BY THE ACA[2]	**PARTICIPATING**	**NONPARTICIPATING**
Office Visits (PCP/SCP)[1]	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Not Covered
VISION SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Pediatric Preventive Eye Exams - Through Age 18 Years, Only[2]	Covered 100%	Not Covered
Adult Preventive Eye Exams - Age 19 and Over[2]	Covered 100%	Not Covered
All Other Eye Exams - Adult/Pediatric	$40	50% after deductible
Contacts and Corrective Lenses - Through Age 18 Years, Only	20% after deductible	50% after deductible
Limit one pair of eyeglass lenses or contact lenses per year		
OUTPATIENT SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Outpatient Facility and Ambulatory Surgical	20% after deductible	50% after deductible
Ambulance (Air or Ground) - *emergencies only*	20% after deductible	See Participating Benefit
Emergency Room Participating Facility	$350 after deductible	See Participating Benefit
Emergency Room Nonparticipating Facility	$350 after deductible	See Participating Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$40	50% after deductible
Intermountain KidsCare® Facilities	$25	Not Available
Intermountain Connect Care®	$10	Not Available
Chemotherapy, Radiation, Dialysis	20% after deductible	50% after deductible
Diagnostic Tests: Minor	Covered 100%	50% after deductible
Diagnostic Tests: Major	20% after deductible	50% after deductible
Home Health[3]	20% after deductible	50% after deductible
Hospice[3]	20% after deductible	50% after deductible
Outpatient Private Nurse[3]	20% after deductible	50% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational	$40 after deductible	50% after deductible
Up to 20 visits/calendar year for all therapy types combined		
Outpatient Habilitative Therapy: Physical, Speech, Occupational	$40 after deductible	50% after deductible
Up to 20 visits/calendar year for all therapy types combined		

See next page for additional benefits and footnotes.

MISCELLANEOUS SERVICES	PARTICIPATING	NONPARTICIPATING
Maternity and Adoption[3,5] *Includes all related maternity and adoption services. Enroll in SelectHealth Healthy Beginnings Program® : 866-442-5052*	See Professional, Inpatient, or Outpatient Services	See Professional, Inpatient, or Outpatient Services
Chiropractic Care *Up to 15 visits/calendar year*	Not Covered	50% after deductible
Miscellaneous Medical Supplies (MMS)[2]	20% after deductible	50% after deductible
Durable Medical Equipment (DME)[3]	20% after deductible	50% after deductible
Prosthetic Devices[3]	20% after deductible	50% after deductible
Injectable Drugs and Specialty Medications[3]	30% after deductible	50% after deductible
Infertility *(select services only)* *Maximum plan payment: up to $1,500/calendar year; $5,000/lifetime*	50% after deductible	Not Covered
Pediatric Dental, SelectHealth Classic Network *(through 18 years)* *Oral examinations and cleanings - two per calendar year*	$40	Not Covered
Mental Health and Chemical Dependency[3]		
Office Visits	$25	50% after deductible
Inpatient	20% after deductible	50% after deductible
Outpatient	20% after deductible	50% after deductible
Residential Treatment Center	20% after deductible	50% after deductible
Cochlear Implants[3]	See Professional, Inpatient, or Outpatient Services	Not Covered
Donor Fees for Organ Transplants[3]	See Professional, Inpatient, or Outpatient Services	Not Covered
TMJ (Temporomandibular Joint) Services *Up to $2,000/lifetime*	See Professional, Inpatient, or Outpatient Services	Not Covered

PRESCRIPTION DRUGS[3]	
Prescription Drug List (formulary)	RxSelect®
Prescription Drug Deductible - *Per Person*	None
Out-of-Pocket Maximum	Combined with medical
Copay – *Up to 30-day supply for covered medications; generic substitution required*	
Tier 1	$15
Tier 2	$25
Tier 3	25%
Tier 4	50%
Tier 5	30%
Maintenance Drug – *90-day supply (Mail-Order, Retail90®); generic substitution required*	
Tier 1	$15
Tier 2	$25
Tier 3	25%
Tier 4	50%

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 and MMS services.
3. Preauthorization is required for certain services. Benefits may be reduced or denied if you do not preauthorize certain services with nonparticipating 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. Nonparticipating 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. 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.

All covered services obtained outside the United States, except for routine, urgent, or emergency conditions require preauthorization.

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.

Benefits are administered and underwritten by SelectHealth, Inc. SM *(domiciled in Utah)*