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

| MED NETWORK The production of the product product years are provided and provided product years are producted by the product product years are provided and provided product years are producted by the product years are provided | This is a Gold plan as defined by the Affordable Care Act | | | |
|---|--|--|--|--|
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| DEDICTION RAND OUT-OF-FOCKET MAXIMUM** Self Only Growings, I person emobiles per calendar Year Deductible Self Only Growings, I person emobiles per calendar Year Deductible Deductible per person family Sy, 78,90 S2,000 S5,000 S5,0 | Selectificanti, | | When using Out-of-Network Providers, you are | |
| Self Colly Coverage, I person corolled - per calendar Year Destactible Data of Parks Maximum S1,350 S2,000 S5,000 S1,000 Data of Parks Maximum S1,350 S2,000 S5,000 | | responsible to pay the amounts in this column. | responsible to pay the amounts in this column. | |
| Deductible S.2.00 S.3.00 S.3.00 Dut-of-Procket Maximum S.3.50 S.3.00 | DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM ^{4,5} | IN-NETWORK | OUT-OF-NETWORK | |
| Supplied | Self Only Coverage, 1 person enrolled - per calendar Year | | | |
| Family Coverage, Zor mose emulated per calendar Year | Deductible | \$2,000 | \$5,000 | |
| Dedictible - per person/family \$2,000.84,000 \$5,000.81,000 \$1,000.81,000.81,000 \$1,000.81,000.81,000 \$1,000.81,000.81,000 \$1,000.81 | Out-of-Pocket Maximum | \$7,350 | \$20,000 | |
| ST-350314-700 ST-2000-St-0 | Family Coverage, 2 or more enrolled - per calendar Year | | | |
| This amount is your Deductible your Coinsurance and Copey (medical and Rr) INNETINORIS Medical, Surgical, Hospice, Emergency Admissions Skilial Nariong Facility 15% after Deductible 15% after Deductible 25% after D | Deductible - per person/family | \$2,000/\$4,000 | \$5,000/\$10,000 | |
| Medical, Surgical, Hospice, Emergency Admissions ISW after Deductible JOB 100 Masy Acute De | * * | \$7,350/\$14,700 | \$20,000/\$40,000 | |
| Medical, Surgical, Hospice, Emergency Admissions 15% after Deductible 50% after Deductible 15% after Deduc | | | | |
| Skilled Nursing Facility Ip 10 Alloyshordedur Year Rohat Therapy: Physical, Speech, Occupational Ip 10 Alloyshordedur Year for all therapy types combined Physician's Fees - Medical, Surgical, Maternity, Anesthesia PROFESSIONAL SERVICES Thirty Care Provider (PCP) S15 | INPATIENT SERVICES | IN-NETWORK | OUT-OF-NETWORK | |
| Relab Therappe Systical, Speech, Occupational Sign after Deductible 50% after Deductible Sign | Medical, Surgical, Hospice, Emergency Admissions | 15% after Deductible | 50% after Deductible | |
| Rehab Therapy: Physical, Speech, Occupational (by 60 dhays-videndue) Two fired liberapy: types combined Physician's Fees - Medical, Surgical, Maternity, Anesthesia PROPESSIONAL SERVICES OUT-OF-NETWORK ON Covered Secondary Care Provider (PCP) | | 15% after Deductible | 50% after Deductible | |
| Up to 40 days/calendar Vare for all therapy types combined Physician's Fees - Medical, Surgical, Maternity, Anesthesia 15% after Deductible 50% after De | | | | |
| Physician's Fees - Medical, Surgical, Maternity, Anesthesia Office Visits and Office Surgeries Primary Care Provider (PCP) Primary Care Provider (PCP) S15 S0% after Deductible Not Covered Scoondary Care Provider (PCP) S10 S20 Somitary Care Provider (PCP) S20 Se office visits Not Covered S20 S41 S42 S42 S43 S44 S45 S45 S45 S46 S47 S47 S47 S47 S47 S47 S47 | | \$30 after Deductible | 50% after Deductible | |
| Office Visits and Office Surgeries Primary Care Provider (PCP) Primary Care Pr | | 150/ C D 1 (71) | 500/ G D L (11 | |
| Office Visits and Office Surgeries Primary Care Provider (PCP) Provider Provider Provider Provider Provider Provision Primary Care Provider Provider Provider Provider Provider Provider Provision Primary Care Provision Primary Care Provision Primary Care Provision Primary Care P | | | | |
| Primary Care Provider (PCP) Virtual Visits Covered 100% Not Covered Secondary Care Provider (PCP) Virtual Visits Covered 100% Soft after Deductible Secondary Care Provider (SCP) Soft after Deductible Soft after | | IN-NETWORK | OUT-OF-NETWORK | |
| Primary Care Provider (PCP) Virtual Visits Secondary Care Provider (SCP) Secondary Care Provider Deductible Secondary Care Provider Deductible Secondary Care Provider Deductible Secondary Care Provider (SCP) Secondary Care Provider Deductible Secondary Care Provider (SCP) | | | | |
| Secondary Care Provider (SCP) ¹ Allergy Tests Allergy Treatment and Serum Physician's Fees - Surgical Physician's Fees - Surgical Physician's Fees - Medical, Maternity, Anesthesia 15% after Deductible 50% after Deductible 70 | | | | |
| Allergy Treatment and Serum Physician's Fees - Surgical Allergy Treatment and Serum Physician's Fees - Surgical Physician's Fees - Surgical Physician's Fees - Medical, Maternity, Anesthesia Office Visits (PCPSCP) Covered 100% Office Visits (PCPSCP) Adult and Pediatric Immunizations Covered 100% Office Visits (PCPSCP) Adult and Pediatric Immunizations Covered 100% Office Preventive Services Office Preventive Services VISION SERVICES IN. NETWORK OUT-OF-NETWORK Podiatric Preventive Eye Exams - Age 19 and Over² Covered 100% Not Covered Adult Preventive Eye Exams - Age 19 and Over² Covered 100% Not Covered All Other Eye Exams - Age 19 and Over² Covered 100% Not Covered All Other Eye Exams - Age 19 and Over² Covered 100% Not Covered All Other Eye Exams - Age 19 and Over² Soffice Through Age 18 Years, Only In the Eye Exams - Age 19 and Over² Soffice Through Age 18 Years, Only In the Eye Exams - Age 19 and Over² Covered 100% Not Covered All Other Eye Exams - Age 19 and Over² Soffice Through Age 18 Years, Only In the Eye Exams - Age 19 and Over² Soffice Through Age 18 Years, Only In the Eye Exams - Age 19 and Over² Soffice Through Age 18 Years, Only In the Eye Exams - Age 19 and Over² Soffice Through Eye Exams - Age 19 and Over² Soffice Through Eye Exams - Age 19 and Over² Soffice Through Eye Exams - Age 19 and Over² Soffice Through Eye Exams - Age 19 and Over² Soffice Through Eye Exams - Age 19 and Over² Soffice Through Eye Exams - Age 19 and Over² Soffice Through Eye Exams - Age 19 and Over² Soffice Through Eye Exams - Age 19 and Over² Soffice Through Eye Exams - Age 19 and Over² Soffice Through Eye Exams - Age 19 and Over² Soffice Through Eye Exams - Age 19 and Over² Soffice Through Eye Exams - Age 19 and Over² Soffice Through Eye Exams - Age 19 and Over? Soffice Through Eye Exams - Age 19 and Over? Soffice Through Eye E | | | | |
| Allergy Treatment and Serum Physician's Fees - Surgicul Physician's Fees - Medical, Maternity, Anesthesia 15% after Deductible 15% after Deductible 50% aft | | · · | | |
| Physician's Fees - Surgical Physician's Fees - Medical, Maternity, Anesthesia Physician's Fees - Medical Ph | | | | |
| Physician's Fees - Medical, Maternity, Anesthesia PREVENTIVE CARE AS OUTLINED BY THE ACA ² Office Visis (PCP/SCP) ¹ Covered 100% And Covered 100% And Covered 100% Not | | | | |
| PREVENTIVE CARE AS OUTLINED BY THE ACA ² Office Visits (PCPSCP) ¹ Adult and Pediatric Immunizations Diagnostic Tests: Minor Other Preventive Services Covered 100% Not Covered Other Preventive Services Covered 100% Not Covered Other Preventive Services Postage In-Network Eye Exams - Through Age 18 Years, Only ² Adult Preventive Eye Exams - Adult Pediatric Covered 100% Not Covered Other Preventive Eye Exams - Adult Prediatric Sao Solv after Deductible Solv after | , · | | | |
| Office Visits (PCP/SCP)\footnote{1} Adult and Pediatric Immunizations Diagnostic Tests: Minor Other Preventive Services Other Preventive Services Other Preventive Services NNNETWORK OUT-OF-NETWORK VISION SERVICES NOT Covered 100% Not Covered VISION SERVICES NNNETWORK OUT-OF-NETWORK Pediatric Preventive Eye Exams - Through Age 18 Years, Only\footnote{2} Adult Preventive Eye Exams - Age 19 and Over\footnote{2} All Other Eye Exams - Adult/Pediatric Contacts and Corrective Lenses - Through Age 18 Years, Only Limit one pair of eye glass lenses or contact lenses per Year OUTPATIENT SERVICES IN-NETWORK OUT-OF-NETWORK OUT-OF-NETWORK OUT-OF-NETWORK OUTPATIENT SERVICES IN-NETWORK OUT-OF-NETWORK OUTPATIENT SERVICES IN-NETWORK OUT-OF-NETWORK OUTPATIENT SERVICES IN-NETWORK OUT-OF-NETWORK OUTPATIENT SERVICES IN-NETWORK OUT-OF-NETWORK OUTPATIENT SERVICES IN-NETWORK OUT-OF-NETWORK OUT-OF-NETWORK OUT-OF-NETWORK OUT-OF-NETWORK OUTPATIENT SERVICES IN-NETWORK OUT-OF-NETWORK OUT-OF-NETWO | | 15% after Deductible | 50% after Deductible | |
| Adult and Pediatric Immunizations Diagnostic Tests: Minor Covered 100% Diagnostic Tests: Minor Covered 100% Covered 100% Not Covered Not Covered Not Covered VISION SERVICES IN-NETWORK Pediatric Preventive Eye Exams - Through Age 18 Years, Only Adult Preventive Eye Exams - Age 19 and Over Adult Preventive Eye Exams - Age 19 and Over Adult Preventive Eye Exams - Age 19 and Over Adult Preventive Eye Exams - Age 19 and Over Adult Preventive Eye Exams - Age 19 and Over Adult Preventive Eye Exams - Age 19 and Over Adult Preventive Eye Exams - Age 19 and Over Adult Preventive Eye Exams - Age 19 and Over Adult Preventive Eye Exams - Age 19 and Over Adult Preventive Eye Exams - Age 19 and Over Adult Preventive Eye Exams - Age 19 and Over Adult Preventive Eye Exams - Age 19 and Over Adult Preventive Eye Exams - Age 19 and Over Sow after Deductible Contacts and Corrective Lenses - Through Age 18 Years, Only Limit one pair of eyeglass lenses or contact lenses per Year OUTPATIENT SERVICES IN-NETWORK OUT-OF-NETWORK Not Covered 100% See In-Network Benefit See I | PREVENTIVE CARE AS OUTLINED BY THE ACA ² | IN-NETWORK | OUT-OF-NETWORK | |
| Diagnostic Tests: Minor Other Preventive Services Covered 100% Not Covered Covered 100% Not Covered Adult Preventive Eye Exams - Through Age 18 Years, Only² Adult Preventive Eye Exams - Age 19 and Over² Covered 100% Not Covered All Other Eye Exams - Adult/Pediatric Sa0 S0% after Deductible S0% after Deductible Limit one pair of eyeglass lenses or contact lenses per Year OUTPATIENT SERVICES NouTester Ambulance (Air or Ground) - emergencies only Emergency Room In-Network Facility Emergency Room In-Network Facility Emergency Room Out-of-Network Facility Emergency Room Out-of-Network Facilities Intermountain InstaCare® Facilities, Urgent Care Facilities Intermountain InstaCare® Facilities Intermountain Connect Care® Covered 100% Not Available Intermountain Connect Care® Covered 100% Not Available Diagnostic Tests: Minor, per Provider Diagnostic Tests: Minor, per Prov | Office Visits (PCP/SCP) ¹ | Covered 100% | Not Covered | |
| Other Preventive Services VISION SERVICES RN-NETWORK Pediatric Preventive Eye Exams - Through Age 18 Years, Only ² Adult Preventive Eye Exams - Age 19 and Over ² All Other Eye Exams - Age 19 and Over ² All Other Eye Exams - Age 19 and Over ² All Other Eye Exams - Age 19 and Over ² All Other Eye Exams - Adult Prediatric Contacts and Corrective Lenses - Through Age 18 Years, Only Limit one pair of eyeglass lenses or contact lenses per Year OUTPATIENT SERVICES IN-NETWORK OUTPATIENT SERVICES OUtpatient Facility and Ambulatory Surgical Ambulance (Air or Ground) - emergencies only Emergency Room In-Network Facility Emergency Room In-Network Facility Intermountain InstaCare® Facilities, Urgent Care Facilities Intermountain InstaCare® Facilities, Urgent Care Facilities Intermountain InstaCare® Facilities, Urgent Care Facilities Intermountain Connect Care® Covered 100% Not Available Intermountain Connect Care® Covered 100% Intermountai | Adult and Pediatric Immunizations | Covered 100% | Not Covered | |
| Pediatric Preventive Eye Exams - Through Age 18 Years, Only ² Pediatric Preventive Eye Exams - Age 19 and Over ² Covered 100% Adult Preventive Eye Exams - Age 19 and Over ² Covered 100% Not Covered Adult Preventive Eye Exams - Age 19 and Over ² Covered 100% Not Covered Some Adult Prediatric Contacts and Corrective Lenses - Through Age 18 Years, Only 15% after Deductible Diagnostic Testility and Ambulatory Surgical Ambulance (Air or Ground) - emergencies only 15% after Deductible See In-Network Benefit See In-Network Facility Some Adult Predictible See In-Network Benefit Some Age 18 Years, Only 15% after Deductible See In-Network Benefit Some Age 18 Years, Only 15% after Deductible See In-Network Benefit Some Age 18 Years, Only 15% after Deductible See In-Network Benefit Some Age 18 Years, Only 15% after Deductible See In-Network Benefit Some Age 18 Years, Only 18 Years Some Some In-Network Benefit Some Age 18 Years, Only 18 Years Some Some In-Network Benefit Some Age 18 Years Some Some Some Some Some Some Some Some | Diagnostic Tests: Minor | Covered 100% | Not Covered | |
| Pediatric Preventive Eye Exams - Through Age 18 Years, Only ² Adult Preventive Eye Exams - Age 19 and Over ² All Other Eye Exams - Age 19 and Over ² All Other Eye Exams - Adult/Pediatric Contacts and Corrective Lenses - Through Age 18 Years, Only Limit one pair of eyeglass lenses or contact lenses per Year OUTPATIENT SERVICES IN-NETWORK OUTJATIENT SERVICES OUTPATIENT SERVICES IN-NETWORK OUTJATIENT SERVICES OUTJATIENT SERVICES IN-NETWORK OUTJATIENT SERVICES IN-NETWORK OUTJATIENT SERVICES OUTJATIENT SERVICES OUTJATIENT SERVICES IN-NETWORK OUTJATIENT SERVICES OUTJATIENT SERVICES OUTJATIENT SERVICES OUTJATIENT SERVICES IN-NETWORK OUTJATIENT SERVICES OUTJATIENT SERVICES OUTJATIENT SERVICES IN-NETWORK OUTJATIENT SERVICES OUTJATIENT SA | Other Preventive Services | Covered 100% | Not Covered | |
| Adult Preventive Eye Exams - Age 19 and Over ² All Other Eye Exams - Adult/Pediatric Contacts and Corrective Lenses - Through Age 18 Years, Only Limit one pair of eyeglass lenses or contact lenses per Year OUTPATIENT SERVICES IN-NETWORK Outpatient Facility and Ambulatory Surgical Ambulance (Air or Ground) - emergencies only Emergency Room In-Network Facility Emergency Room In-Network Facility Emergency Room Out-of-Network Facility Emergency Room Out-of-Network Facility Emergency Room Out-of-Network Facilities Intermountain InstaCarc® Facilities, Urgent Care Facilities Intermountain Connect Care® Radiation Intermountain Connect Care® Radiation Diagnostic Tests: Minor, per Provider Diagnostic Tests: Major, per Provider Uniquation Facility Home Health Home Health Home Health Outpatient Cardiac Rehab Outpatient Cardiac Rehab Outpatient Raba Therapy: Physical, Speech, Occupational Up to 20 visits/Calendar Year for all therapy types combined All Other Sad Sad Som after Deductible Diavisits/Calendar Year for all therapy types combined Outpatient Habilitative Therapy: Physical, Speech, Occupational Up to 20 visits/Calendar Year for all therapy types combined All Other Sad Sad Som after Deductible Diavisits/Calendar Year for all therapy types combined Outpatient Habilitative Therapy: Physical, Speech, Occupational Up to 20 visits/Calendar Year for all therapy types combined | VISION SERVICES | IN-NETWORK | OUT-OF-NETWORK | |
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| Contacts and Corrective Lenses - Through Age 18 Years, Only Limit one pair of eyeglass lenses or contact lenses per Year OUTATIENT SERVICES Outpatient Facility and Ambulatory Surgical Ambulance (Air or Ground) - emergencies only Emergency Room In-Network Facility Emergency Room In-Network Facility Emergency Room Out-of-Network Facility Emergency Room Out-of-Network Facility Intermountain InstaCare® Facilities, Urgent Care Facilities Intermountain Connect Care® Covered 100% Dialysis Diagnostic Tests: Minor, per Provider Diagnostic Tests: Major, per Provider Hospica® Hospica® Outpatient Cardiac Rehab Outpatient Cardiac Rehab Outpatient Cardiac Rehab Outpatient Rabi Therapy: Physical, Speech, Occupational Up to 20 visits/calendar Year for all therapy types combined NOT-OF-NETWORK NUT-OF-NETWORK DIS-NETWORK OUT-OF-NETWORK NUT-OF-NETWORK DIS-NETWORK OUT-OF-NETWORK SUB-NETWORK OUT-OF-NETWORK DIS-NETWORK OUT-OF-NETWORK DIS-NETWORK OUT-OF-NETWORK DIS-NETWORK OUT-OF-NETWORK DIS-Network Benefit See In-Network B | Adult Preventive Eye Exams - Age 19 and Over ² | Covered 100% | Not Covered | |
| Limit one pair of eyeglass lenses or contact lenses per Year OUTPATIENT SERVICES Outpatient Facility and Ambulatory Surgical Ambulance (Air or Ground) - emergencies only Emergency Room In-Network Facility Emergency Room Out-of-Network Facility Emergency Room Out-of-Network Facility Emergency Room Out-of-Network Facility Sa50 after Deductible Emergency Facilities, Urgent Care Facilities Intermountain InstaCare® Facilities, Urgent Care Facilities Intermountain Connect Care® Covered 100% Intermountain Connect Care® Covered 100% Intermountain Connect Care® Intermountain Connect Care® Covered 100% Intermountain Connect Care® Intermountain Care® Intermountain Connect Care® Intermountain Connect Care® Intermountain Care® Intermountain Connect Care® Intermountain Care® Intermou | All Other Eye Exams - Adult/Pediatric | \$30 | 50% after Deductible | |
| OUTPATIENT SERVICES IN-NETWORK OUT-OF-NETWORK Outpatient Facility and Ambulatory Surgical 15% after Deductible 50% after Deductible Ambulance (Air or Ground) - emergencies only 15% after Deductible See In-Network Benefit Emergency Room In-Network Facility \$350 after Deductible See In-Network Benefit Emergency Room Out-of-Network Facilities, Urgent Care Facilities (Urgent Care Facilities) \$350 after Deductible See In-Network Benefit Intermountain InstaCare® Facilities, Urgent Care Facilities \$350 after Deductible See In-Network Benefit Intermountain KidsCare® Facilities, Urgent Care Facilities \$350 after Deductible See In-Network Benefit Intermountain InstaCare® Facilities, Urgent Care Facilities \$350 after Deductible See In-Network Benefit Intermountain InstaCare® Facilities, Urgent Care Facilities \$30 50% after Deductible Intermountain KidsCare® Facilities, Urgent Care Facilities \$30 Not Available Intermountain KidsCare® Facilities \$30 50% after Deductible Badiation 15% after Deductible 50% after Deductible Diagnostic Tests: Minor, per Provider Covered 100% 50% after Deductible Home Health³ | Contacts and Corrective Lenses - Through Age 18 Years, Only | 15% after Deductible | 50% after Deductible | |
| Outpatient Facility and Ambulatory Surgical 15% after Deductible 50% after Deductible Ambulance (Air or Ground) - emergencies only 15% after Deductible See In-Network Benefit Emergency Room In-Network Facility \$350 after Deductible See In-Network Benefit Emergency Room Out-of-Network Facility \$350 after Deductible See In-Network Benefit Intermountain InstaCare® Facilities, Urgent Care Facilities \$30 50% after Deductible Intermountain KidsCare® Facilities \$15 Not Available Intermountain Connect Care® Covered 100% Not Available Radiation 15% after Deductible 50% after Deductible Dialysis 15% after Deductible 50% after Deductible Diagnostic Tests: Minor, per Provider Covered 100% 50% after Deductible Diagnostic Tests: Major, per Provider 15% after Deductible 50% after Deductible Home Health³ 15% after Deductible 50% after Deductible Hospice³ 15% after Deductible 50% after Deductible Outpatient Cardiac Rehab Covered 100% 50% after Deductible Outpatient Private Nurse³ 15% after Deductible 50% after Deductible Outpatient Habilitative Therapy: Ph | Limit one pair of eyeglass lenses or contact lenses per Year | | | |
| Ambulance (Air or Ground) - emergencies only Emergency Room In-Network Facility Emergency Room Out-of-Network Facility Emergency Room Out-of-Network Facility Intermountain InstaCare® Facilities, Urgent Care Facilities Intermountain InstaCare® Facilities Intermountain KidsCare® Facilities Intermountain Connect Care® Radiation Radiation Dialysis Diagnostic Tests: Minor, per Provider Diagnostic Tests: Major, per Provider Diagnostic Tests: Major, per Provider Diagnostic Tests: Major, per Provider Un to Zo visits/calendar Year for all therapy types combined 15% after Deductible See In-Network Benefit So After Deductible Sow after Deductible | OUTPATIENT SERVICES | IN-NETWORK | OUT-OF-NETWORK | |
| Emergency Room In-Network Facility\$350 after DeductibleSee In-Network BenefitEmergency Room Out-of-Network Facility\$350 after DeductibleSee In-Network BenefitIntermountain InstaCare® Facilities, Urgent Care Facilities\$3050% after DeductibleIntermountain KidsCare® Facilities\$15Not AvailableIntermountain Connect Care®Covered 100%Not AvailableRadiation15% after Deductible50% after DeductibleDialysis15% after Deductible50% after DeductibleDiagnostic Tests: Minor, per ProviderCovered 100%50% after DeductibleDiagnostic Tests: Major, per Provider15% after Deductible50% after DeductibleHospice³15% after Deductible50% after DeductibleHospice³15% after Deductible50% after DeductibleOutpatient Cardiac RehabCovered 100%50% after DeductibleOutpatient Private Nurse³15% after Deductible50% after DeductibleOutpatient Rehab Therapy: Physical, Speech, Occupational Up to 20 visits/calendar Year for all therapy types combined\$3050% after DeductibleOutpatient Habilitative Therapy: Physical, Speech, Occupational Up to 20 visits/calendar Year for all therapy types combined\$3050% after Deductible | Outpatient Facility and Ambulatory Surgical | 15% after Deductible | 50% after Deductible | |
| Emergency Room Out-of-Network Facility Intermountain InstaCare® Facilities, Urgent Care Facilities Intermountain KidsCare® Facilities Intermountain KidsCare® Facilities Intermountain Connect Care® Covered 100% Radiation Total Available Radiation Total Safter Deductible Dialysis Total Safter Deductible Diagnostic Tests: Minor, per Provider Diagnostic Tests: Major, per Provider Total Safter Deductible Total Safte | Ambulance (Air or Ground) - emergencies only | 15% after Deductible | See In-Network Benefit | |
| Intermountain InstaCare® Facilities, Urgent Care Facilities Intermountain KidsCare® Facilities Intermountain KidsCare® Facilities Intermountain Connect Care® Radiation Radiation Dialysis Diagnostic Tests: Minor, per Provider Diagnostic Tests: Major, per Provid | Emergency Room In-Network Facility | \$350 after Deductible | See In-Network Benefit | |
| Intermountain KidsCare® Facilities Intermountain Connect Care® Covered 100% Covered 100% Radiation Intermountain Connect Care® Sow after Deductible Dialysis Intermountain Connect Care® Intermountain Connect Care® Covered 100% Intermountain Connect Care® Sow after Deductible Sow after Deductible Covered 100% Intermountain Connect Care® Covered 100% Intermountain Connect Care® Covered 100% Intermountain Connect Care® Covered 100% Intermountain Cardiac Carte Deductible Sow after Deductible Sow after Deductible Intermountain Cardiac Rehab Covered 100% Intermountain Cardiac Rehab Intermountain Cardiac Rehab Covered 100% Intermountain Cardiac Rehab Intermountain Cardiac Rehab Therapy: Physical, Speech, Occupational Intermountain Cardiac Rehab Therapy: Physical, Speech, Occupational Intermountain Cardiac Rehab Therapy: Physical, Speech, Occupational Intermountain Covered 100% Intermountain Cardiac Rehab Intermountain Cardiac Rehab Intermountain Covered 100% Intermountain Cardiac Rehab Inter | Emergency Room Out-of-Network Facility | \$350 after Deductible | See In-Network Benefit | |
| Intermountain Connect Care® Radiation 15% after Deductible 50% after Deductible Dialysis 15% after Deductible Diagnostic Tests: Minor, per Provider Diagnostic Tests: Major, per Provider Diagnostic Tests: Minor, per Provider Diagnostic Tests: Major Deductible Diagnostic Te | Intermountain InstaCare® Facilities, Urgent Care Facilities | \$30 | 50% after Deductible | |
| Radiation 15% after Deductible 50% after Deductible Dialysis 15% after Deductible 15% after Deductible 50% after Deductible Diagnostic Tests: Minor, per Provider Covered 100% 50% after Deductible Diagnostic Tests: Major, per Provider 15% after Deductible 50% after Deductible Home Health ³ 15% after Deductible 50% after Deductible Hospice ³ 15% after Deductible 50% after Deductible Outpatient Cardiac Rehab Covered 100% 50% after Deductible Outpatient Private Nurse ³ 15% after Deductible 50% after Deductible Outpatient Rehab Therapy: Physical, Speech, Occupational 400 15% after Deductible 50% after Deductible | Intermountain KidsCare® Facilities | \$15 | Not Available | |
| Dialysis Dia | Intermountain Connect Care® | Covered 100% | Not Available | |
| Diagnostic Tests: Minor, per Provider Diagnostic Tests: Major, per Provider Diagnostic Tests: Major, per Provider Home Health ³ Hospice ³ Diagnostic Tests: Major, per Provider Hospice ³ Diagnostic Tests: Major, per Provider Home Health ³ Diagnostic Tests: Major, per Provider Diagnostic Tests: Major, per Provider Diagnostic Tests: Major, per Provider Diagnostic Tests: Minor, per Provider Diagnostic Tests: Major, per Provider Diagnostic Tests: Agor Deductible Down after Deductible Dow | Radiation | 15% after Deductible | 50% after Deductible | |
| Diagnostic Tests: Major, per Provider Home Health ³ 15% after Deductible 15% after Deductible 50% after Deductible | Dialysis | 15% after Deductible | 50% after Deductible | |
| Home Health ³ Home Health ³ Hospice ³ 15% after Deductible 15% after | | Covered 100% | 50% after Deductible | |
| Hospice ³ 15% after Deductible 50% after Deductible Outpatient Cardiac Rehab Covered 100% 50% after Deductible Outpatient Private Nurse ³ 15% after Deductible 15% after Deductible 50% after Deductible Outpatient Rehab Therapy: Physical, Speech, Occupational \$30 50% after Deductible Up to 20 visits/calendar Year for all therapy types combined \$30 50% after Deductible Up to 20 visits/calendar Year for all therapy types combined \$30 50% after Deductible Up to 20 visits/calendar Year for all therapy types combined | 3 1 | 15% after Deductible | 50% after Deductible | |
| Outpatient Cardiac Rehab Outpatient Private Nurse ³ Outpatient Rehab Therapy: Physical, Speech, Occupational Up to 20 visits/calendar Year for all therapy types combined Outpatient Habilitative Therapy: Physical, Speech, Occupational Up to 20 visits/calendar Year for all therapy types combined Outpatient Habilitative Therapy: Physical, Speech, Occupational Up to 20 visits/calendar Year for all therapy types combined Covered 100% 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible | | 15% after Deductible | 50% after Deductible | |
| Outpatient Private Nurse ³ Outpatient Rehab Therapy: Physical, Speech, Occupational Up to 20 visits/calendar Year for all therapy types combined Outpatient Habilitative Therapy: Physical, Speech, Occupational Up to 20 visits/calendar Year for all therapy types combined \$30 \$50% after Deductible \$30 \$50% after Deductible | Hospice ³ | | 50% after Deductible | |
| Outpatient Rehab Therapy: Physical, Speech, Occupational Up to 20 visits/calendar Year for all therapy types combined Outpatient Habilitative Therapy: Physical, Speech, Occupational Up to 20 visits/calendar Year for all therapy types combined \$30 \$50% after Deductible \$30 \$50% after Deductible | * | Covered 100% | 50% after Deductible | |
| Up to 20 visits/calendar Year for all therapy types combined Outpatient Habilitative Therapy: Physical, Speech, Occupational Up to 20 visits/calendar Year for all therapy types combined \$30\$ 50% after Deductible | Outpatient Private Nurse ³ | 15% after Deductible | 50% after Deductible | |
| Up to 20 visits/calendar Year for all therapy types combined | | \$30 | 50% after Deductible | |
| | 1 | \$30 | 50% after Deductible | |

| MISCELLANEOUS SERVICES | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---------------------------------|
| Maternity and Adoption ^{3,6} | See Professional, Inpatient, or | See Professional, Inpatient, or |
| Includes all related maternity and adoption services. Enroll in | Outpatient Services | Outpatient Services |
| SelectHealth Healthy Beginnings Program®: 866-442-5052 | | |
| Chiropractic Care | \$20 | 50% after Deductible |
| Up to 10 visits/calendar Year | | |
| Miscellaneous Medical Supplies (MMS) ² | 15% after Deductible | 50% after Deductible |
| Autism Spectrum Disorder | pectrum Disorder See Professional, Inpatient, Outpatien | |
| | or Mental Health and Chemical | or Mental Health and Chemical |
| | Dependency Services | Dependency Services |
| Durable Medical Equipment (DME) ³ | 15% after Deductible | 50% after Deductible |
| Prosthetic Devices ³ | 15% after Deductible | 50% after Deductible |
| Injectable Drugs, Chemotherapy, and Specialty Medications ³ | 25% after Deductible | 50% after Deductible |
| Infertility (select services only) | 50% after Deductible | Not Covered |
| Pediatric Dental, SelectHealth Classic Network (through 18 Years) | \$30 | Not Covered |
| Oral examinations and cleanings - two per calendar Year | | |
| Mental Health and Chemical Dependency ³ | | |
| Office Visits | \$15 | 50% after Deductible |
| Virtual Visits | Covered 100% | 50% after Deductible |
| Inpatient | 15% after Deductible | 50% after Deductible |
| Outpatient | 15% after Deductible | 50% after Deductible |
| Residential Treatment Center | 15% after Deductible | 50% after Deductible |
| Cochlear Implants, Hearing Aids, or Auditory Osseointegrated Devices ³ | See Professional, Inpatient, or | Not Covered |
| One device every 36 months per ear | Outpatient Services | |
| Donor Fees for Organ Transplants ³ | See Professional, Inpatient, or | Not Covered |
| | Outpatient Services | |
| TMJ (Temporomandibular Joint) Services | See Professional, Inpatient, or | Not Covered |
| Up to \$2,000/lifetime | Outpatient Services | |

PRESCRIPTION DRUGS³

| Prescription Drug List (formulary) | RxSelect [®] | | |
|--|--|--|--|
| Prescription Drug Deductible - Per Person | None | | |
| Out-of-Pocket Maximum | Combined with medical | | |
| Prescription Drugs – Up to 30-day supply for covered medications | | | |
| Tier 1 | \$20 | | |
| Tier 2 | \$30 | | |
| Tier 3 | 25% | | |
| Tier 4 | 50% | | |
| Tier 5 | 25% | | |
| Maintenance Drugs – 90-day supply (Mail-Order, Retail90®) | | | |
| Tier 1 | \$20 | | |
| Tier 2 | \$30 | | |
| Tier 3 | 25% | | |
| Tier 4 | 50% | | |
| 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 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.

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. 68781UT0050012-00 01-01-2022

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



Schedule of Benefits

Group Name: Planet Fitness Management

Benefit Plan Name: PPO Plan# 6-115

PCN **** PPO **** NON-NETWORK

| Class I / Preventive | 100% | 100% | 80%** |
|--|-----------------------------|-----------------------------|-----------------------------|
| Class II / Basic | 100% | 90% | 60%** |
| Class III / Major | 70% | 60% | 40%** |
| Benefit Year Deductible Waived for Preventive? Family Deductible | \$25 Yes 3 per Family | \$50 Yes 3 per Family | \$50 Yes 3 per Family |
| Benefit Year Max | \$1,500 | \$1,500 | \$1,500 |
| Class IV / Orthodontia Ortho Coverage Ortho Lifetime Max | 50% Family \$1,000 | 50% Family \$1,000 | 50% Family \$1,000 |
| TMJ Rider TMJ Lifetime Max | No N/A | No N/A | No N/A |
| Wait Period for Major | No Wait | No Wait | No Wait |
| Wait Period for Ortho | | No Wait | No Wait |

^{**} Covered charges are based on the lower of: 1) the dentist's actual charge for the service, 2) the dentist's usual charge for the service, 3) or the UCR amount for the service based on the 90th percentile of dentists in the same geographic area.

^{****} Premier Access does not guarantee all services can be rendered by a contracted PCN or PPO provider. You may be subject to a deductible and co insurance for an out of network Specialist.



Schedule of Benefits

Group Name: Planet Fitness Management

Benefit Plan Name: PPO Plan# 6-115

PCN PPO NON-NETWORK

| Class I / Preventive | Oral Exams, Full Mouth X-Rays/Pano, Bitewings, Other X-Rays, Prophylaxis, Fluoride | Oral Exams, Full Mouth X-Rays/Pano, Bitewings, Other X-Rays, Prophylaxis, Fluoride | Oral Exams, Full Mouth X-Rays/Pano, Bitewings, Other X-Rays, Prophylaxis, Fluoride |
|----------------------|--|--|---|
| Class II / Basic | Sealants, Space Maintainers, Restorations, Emergency(Palliative), Endodontics, Periodontics | Sealants, Space Maintainers, Restorations, Emergency(Palliative), Endodontics, Periodontics | Sealants, Space Maintainers, Restorations, Emergency(Palliative), Endodontics, Periodontics |
| Class III / Major | Inlays, Crowns, Bridges, Dentures, Simple Extractions, Oral Surgery | Inlays, Crowns, Bridges, Dentures, Simple Extractions, Oral Surgery | Inlays, Crowns, Bridges, Dentures, Simple Extractions, Oral Surgery |

How It Works

The Dental Program offered is administrated by Premier Access Insurance Company, a national carrier and widely accepted dental plan.

What is important to know about your dental plan is that you may see any dentist. Although, there are PCN (Premier Choice Network) and PPO provider lists available, and the benefits are enhanced if you elect to use either network, you may elect to see the dentist of your choice without penalty. Using the PCN or PPO providers, you maximize your benefits and reduce your out-of-pocket costs.

The PPO dentists offer discounted care (about 30%) and the plan normally pays a higher level of benefit when using an in-network provider. Additionally, the PCN/PPO dentist cannot "balance bill" you for amounts greater than the contracted rate.

Out-of-State Network and Claims

The Premier Access Dental network is available to eligible members outside the State of California, with nearly 80,000 dentists to choose from. A complete provider listing is available on the internet at: www.premierlife.com. It is important that you confirm with your dentist at the time of treatment that they are participating in the Premier Access network. For a dentist near you call 888.715.0760.

Please check your Certificate of Insurance for a description of coverage, limitations and exclusions under the plan. Some services require prior authorization.

How to Reach Us

Premier Access Claim Dept.
P.O. Box 659010
Sacramento, CA 95865-9010

Member Services Line
888.715.0760

Member Services Line
888.715.0760

www.premierlife.com