



MEMBER PAYMENT SUMMARY

IN-NETWORK

When using In-Network Providers, you are responsible to pay the amounts in this column.

OUT-OF-NETWORK

When using Out-of-Network Providers, you are responsible to pay the amounts in this column.

MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET^{5,6}	IN-NETWORK	OUT-OF-NETWORK
Self Only Coverage, 1 person enrolled - per calendar Year		
Deductible	\$8,000	\$15,000
Out-of-Pocket Maximum	\$9,200	\$18,400
Family Coverage, 2 or more enrolled - per calendar Year		
Deductible - per person/family	\$8000/\$16000	\$15000/\$30000
Out-of-Pocket Maximum - per person/family	\$9200/\$18400	\$18400/\$36800
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
Medical, Surgical and Hospice ⁴	20% after Deductible	40% after Deductible
Skilled Nursing Facility ⁴ - Up to 60 days per calendar Year	20% after Deductible	40% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational ⁴	20% after Deductible	40% after Deductible
Up to 40 days per calendar Year for all therapy types combined		
Physician's Fees - (Medical, Surgical, Maternity, Anesthesia)	20% after Deductible	40% after Deductible
PROFESSIONAL SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP) ¹	\$30	40% after Deductible
Primary Care Provider (PCP) Virtual Visits ¹	Covered 100%	40% after Deductible
Specialist/Secondary Care Provider (SCP) ¹	\$50	40% after Deductible
Allergy Tests	See Office Visits Above	50% after Deductible
Allergy Treatment and Serum	20%	50% after Deductible
Major Surgery	20%	40% after Deductible
Physician's Fees - (Medical, Surgical, Maternity, Anesthesia)	20% after Deductible	40% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA^{2,3}	IN-NETWORK	OUT-OF-NETWORK
Primary Care Provider (PCP) ¹	Covered 100%	50% after Deductible
Specialist/Secondary Care Provider (SCP) ¹	Covered 100%	50% after Deductible
Adult and Pediatric Immunizations	Covered 100%	50% after Deductible
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	50% after Deductible
Diagnostic Tests: Minor	Covered 100%	50% after Deductible
Other Preventive Services	Covered 100%	50% after Deductible
VISION SERVICES	IN-NETWORK	OUT-OF-NETWORK
Preventive Eye Exams	Covered 100%	50% after Deductible
All Other Eye Exams	\$50	40% after Deductible
OUTPATIENT SERVICES¹	IN-NETWORK	OUT-OF-NETWORK
Outpatient Facility and Ambulatory Surgical	20% after Deductible	40% after Deductible
Ambulance (Air or Ground) - <i>Emergencies Only</i>	20% after Deductible	See In-Network Benefit
Emergency Room	\$250 then 20% after Deductible	See In-Network Benefit
Urgent Care Facilities	\$75	40% after Deductible
Intermountain Connect Care [®]	Covered 100%	See Professional, Inpatient, Outpatient, or Miscellaneous Services
Radiation	20% after Deductible	40% after Deductible
Dialysis	20% after Deductible	40% after Deductible
Diagnostic Tests: Minor ²	Covered 100%	40% after Deductible
Diagnostic Tests: Major ²	20% after Deductible	40% after Deductible
Home Health, Hospice, Outpatient Private Nurse	20% after Deductible	40% after Deductible
Outpatient Cardiac Rehab	Covered 100%	40% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	\$50 after Deductible	40% after Deductible



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MISCELLANEOUS SERVICES		
Durable Medical Equipment (DME) ⁴	20% after Deductible	40% after Deductible
Miscellaneous Medical Supplies (MMS) ³	20% after Deductible	40% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity ⁴	See Professional, Inpatient or Outpatient	40% after Deductible
Cochlear Implants, Hearing Aids, or Auditory Osseointegrated Devices ^{2,4} <i>One device every 36 months per ear. Up to 45 language/speech therapy visits during the 12 months after the delivery of the covered device.</i>	See Professional, Inpatient or Outpatient	50% after Deductible
Infertility - Select Services	50% after Deductible	*50% after Deductible
TMJ (Temporomandibular Joint) Services - <i>Up to \$2,000 lifetime</i>	See Professional, Inpatient or Outpatient	50% after Deductible
OPTIONAL BENEFITS		
Mental Health and Substance Use Disorder ⁴		
Office Visits	\$30	40% after Deductible
Virtual Visits	Covered 100%	40% after Deductible
Inpatient	20% after Deductible	40% after Deductible
Outpatient	20%	40% after Deductible
Residential Treatment ²	20% after Deductible	40% after Deductible
Chiropractic <i>(up to 20 visits per calendar Year)</i>	\$30	*50% after Deductible
Healthcare Provider Administered Injectable or Infusible Drugs ⁴	20% after Deductible	40% after Deductible
Bariatric Surgery <i>(Up to one surgery/lifetime)</i> ⁴	See Professional, Inpatient or Outpatient	50% after Deductible
PRESCRIPTION DRUGS		
Pharmacy Deductible - Per Person per calendar Year		\$1,500
Prescription Drug List (formulary)		RxSelect®
Prescription Drugs - <i>Up to 30 Day Supply of Covered Medications</i> ⁴		
Tier 1		\$15
Tier 2		\$30 after pharmacy Deductible
Tier 3		\$50 after pharmacy Deductible
Tier 4		\$100 after pharmacy Deductible
Maintenance Drugs - <i>90 Day Supply (Mail-Order, Retail90®)-selected drugs</i> ⁴		
Tier 1		\$15
Tier 2		\$60 after pharmacy Deductible
Tier 3		\$150 after pharmacy Deductible
Generic Substitution Required		Generic required or must pay Copay plus cost difference between name brand and generic

1 Refer to selecthealth.org/findadoctor to identify whether a Provider is a primary or secondary care Provider.

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some Preventive care and MMS Services.

4 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.

5 All Deductible/Copay/Coinsurance amounts are based on the Allowed Amount and not on billed charges. Out-of-Network Providers or Facilities may not accept the Allowed Amount for Covered Services. When this occurs, you may be responsible for Excess Charges.

6 Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.

* Not applied to Medical Out-of-Pocket Maximum.

All Covered Services obtained outside the United States, except for routine, Urgent, or Emergency conditions require preauthorization.

To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., 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).

ID-MPS 01/01/25

05/14/25