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MED NETWORK / HSA QUALIFIED

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SCHEDULE OF BENEFITS	IN-NETWORK
	When using In-Network Providers, you are responsible to pay the amounts in this column. Services from Out-of-Network Providers are not covered (except emergencies).
CONDITIONS AND LIMITATIONS	
Lifetime Maximum Plan Payment - *Per Person*	None
Pre-Existing Conditions (PEC)	None
Benefit Accumulator Period	calendar Year
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	**IN-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar Year	
Deductible	$2,500
Out-of-Pocket Maximum	$3,500
Family Coverage, 2 or more enrolled - per calendar Year	
Deductible	$5,000
Out-of-Pocket Maximum	$7,000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)	
INPATIENT SERVICES	**IN-NETWORK**
Medical, Surgical and Hospice[4]	20% after Deductible
Skilled Nursing Facility[4] - Up to 60 days per calendar Year	20% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after Deductible
Up to 40 days per calendar Year for all therapy types combined	
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible
PROFESSIONAL SERVICES	**IN-NETWORK**
Office Visits & Minor Office Surgeries	
Primary Care Provider (PCP)[1]	$15 after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	$15 after Deductible
Secondary Care Provider (SCP)[1]	$25 after Deductible
Allergy Tests	See Office Visits Above
Allergy Treatment and Serum	20% after Deductible
Major Surgery	20% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%
Secondary Care Provider (SCP)[1]	Covered 100%
Adult and Pediatric Immunizations	Covered 100%
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%
Diagnostic Tests: Minor	Covered 100%
Other Preventive Services	Covered 100%
VISION SERVICES	**IN-NETWORK**
Preventive Eye Exams	Covered 100%
All Other Eye Exams	$25 after Deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**
Outpatient Facility and Ambulatory Surgical	20% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after Deductible
Emergency Room - *(In-Network facility)*	$75 after Deductible
Emergency Room - *(Out-of-Network facility)*	$75 after Deductible
Intermountain InstaCare℠ Facilities, Urgent Care Facilities	$35 after Deductible
Intermountain KidsCare℠ Facilities	$15 after Deductible
Intermountain Connect Care℠	Covered 100% after Deductible
Radiation and Dialysis	20% after Deductible
Diagnostic Tests: Minor[2]	Covered 100% after Deductible
Diagnostic Tests: Major[2]	20% after Deductible
Home Health, Hospice, Outpatient Private Nurse	20% after Deductible
Outpatient Cardiac Rehab	Covered 100% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$25 after Deductible
Up to 20 visits per calendar Year for each therapy type	

See other side for additional benefits

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MED NETWORK / HSA QUALIFIED

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SCHEDULE OF BENEFITS

IN-NETWORK

MISCELLANEOUS SERVICES	IN-NETWORK
Durable Medical Equipment (DME)[4]	20% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity and Adoption[4,7]	See Professional, Inpatient or Outpatient
Cochlear Implants[4]	See Professional, Inpatient or Outpatient
Infertility - *Selected Services*	50% after Deductible
Donor Fees for Covered Organ Transplants[4]	20% after Deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient
OTHER BENEFITS	**IN-NETWORK**
Mental Health and Chemical Dependency[1]	
Office Visits	$15 after Deductible
Virtual Visits	$15 after Deductible
Inpatient	20% after Deductible
Outpatient	20% after Deductible
Residential Treatment[2]	20% after Deductible
Injectable Drugs, Chemotherapy, and Specialty Medications[4]	20% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient
PRESCRIPTION DRUGS	
Prescription Drugs - *Not Administered by SelectHealth*	Not Covered

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

2 Refer to your Summary Plan Description 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 Summary Plan Description, for details

5 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. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

6 Certain Services as noted on this document and in your Summary Plan Description are not subject to the Deductible

7 SelectHealth provides a $4000 adoption indemnity as outlined by the state of Utah. Medical Deductible, Copay, or Coinsurance listed under the benefit applies and may exhaust the benefits prior to any plan payments

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 by SelectHealth.

NAVITUS - PHARMACY	IN-NETWORK
Pharmacy Coverage	Navitus Information about **prescription drug coverage** is available at 1-844-268-9789 or www.navitus.com
Generic Drugs	
Retail	$7 copay
Mail Order	$7 copay
Preferred Brand-Name Drugs	
Retail	$21 copay
Mail Order	$42 copay
Non-Preferred Brand-Name Drugs	
Retail	$42 copay
Mail Order	$126 copay
Retail Out-of-Network Coverage	Not Covered
Standard Specialty Drugs	
Preferred Brand Specialty	$100 copay
Non-Preferred Brand Specialty	$100 copay
Pharmacy Day Supply and Requirements	
Retail	Up to a 30 day supply from Navitus Network providers
Mail Order	A 31-90 day supply from Navitus Network providers

Specialty	Up to a 30-day supply Navitus Specialty pharmacy Note: Enrollment in Specialty Access Program (SAP) for certain specialty drugs is mandatory and requires prior authorization through Navitus