# Value Gold 1000 Medical Deductible - no deductible for Rx

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

Select Health 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 | $1,000 |
| Out-of-Pocket Maximum | $8,950 |
| Family Coverage, 2 or more enrolled - per calendar Year | |
| Deductible - per person/family | $1,000/$2,500 |
| Out-of-Pocket Maximum - per person/family | $8,950/$17,900 |
| *This amount is your Deductible + your Coinsurance and Copay (medical and Rx)* | |
| *The deductible only applies on lines where "after deductible" is noted* | |
| **INPATIENT SERVICES[3]** | **IN-NETWORK** |
| Medical, Surgical, Hospice, Emergency Admissions | 25% after Deductible |
| Hospital level care at home | 25% after Deductible |
| Skilled Nursing Facility | 25% after Deductible |
| *Up to 60 days/calendar Year* | |
| Rehab Therapy: Physical, Speech, Occupational | $40 after Deductible |
| *Up to 40 days/calendar Year for all therapy types combined* | |
| Physician's Fees – *Medical, Surgical, Maternity, Anesthesia* | 25% after Deductible |
| **PROFESSIONAL SERVICES[3]** | **IN-NETWORK** |
| Office Visits and Office Surgeries | |
| Primary Care Provider (PCP)[1] | $20 |
| Primary Care Provider (PCP) Virtual Visits[1] | Covered 100% |
| Specialist/Secondary Care Provider (SCP)[1] | $40 |
| Allergy Tests | See office visits |
| Allergy Treatment and Serum | 25% |
| Physician's Fees – *Surgical* | 25% after Deductible |
| Physician's Fees – *Medical, Maternity, Anesthesia* | 25% 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] | Covered 100% |
| All Other Eye Exams - Adult/Pediatric | $40 |
| Contacts and Corrective Lenses - Through Age 18 Years, Only | 25% after Deductible |
| *Limit one pair of eyeglass lenses or contact lenses per Year* | |
| **OUTPATIENT SERVICES** | **IN-NETWORK** |
| Outpatient Facility | 25% after Deductible |
| Ambulatory Surgical Center | 15% after Deductible |
| Imaging Center | $70 after Deductible |
| Ambulance (Air or Ground) – *emergencies only* | 25% after Deductible |
| Emergency Room | $350 after Deductible |
| Intermountain InstaCare® Facilities, Urgent Care Facilities | $40 |
| Intermountain KidsCare® Facilities | $20 |
| Intermountain Connect Care® | Covered 100% |
| Radiation | 25% after Deductible |
| Dialysis | 25% after Deductible |
| Diagnostic Tests: Minor, per Provider | Covered 100% |
| Diagnostic Tests: Major, per Provider | 25% after Deductible |
| Home Health[3] | 25% after Deductible |
| Hospice[3] | 25% after Deductible |
| Outpatient Cardiac Rehab | Covered 100% |
| Outpatient Private Nurse[3] | 25% after Deductible |
| Outpatient Rehab Therapy: Physical, Speech, Occupational | $25 |
| *Up to 20 visits/calendar Year for all therapy types combined* | |
| Outpatient Habilitative Therapy: Physical, Speech, Occupational | $35 |
| *Up to 20 visits/calendar Year for all therapy types combined* | |



*See next page for additional benefits and footnotes.*

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| **MISCELLANEOUS SERVICES** | **IN-NETWORK** |
| Maternity and Adoption[3,6] | See Professional, Inpatient, or Outpatient Services |
| *Includes all related maternity and adoption services. Enroll in Select Health Healthy Beginnings Program®: 866-442-5052* | |
| Chiropractic Care | $20 |
| *Up to 10 visits/calendar Year* | |
| Miscellaneous Medical Supplies (MMS)[2] | 25% after Deductible |
| Autism Spectrum Disorder | See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services |
| Durable Medical Equipment (DME)[3] | 25% after Deductible |
| Prosthetic Devices[3] | 25% after Deductible |
| Healthcare Provider Administered Injectable or Infusible Drugs[3] | 50% |
| Chemotherapy[3] | 50% |
| Infertility (*select services only)* | 50% after Deductible |
| Pediatric Dental, Select Health Classic Network *(through 18 Years)* | $40 |
| *Oral examinations and cleanings - two per calendar Year* | |
| Mental Health and Substance Use Disorder[3] | |
| Office Visits | $20 |
| Virtual Visits | Covered 100% |
| Inpatient | 25% after Deductible |
| Outpatient | 25% after Deductible |
| Residential Treatment Center | 25% after Deductible |
| Cochlear Implants or Auditory Osseointegrated Devices[3] | See Professional, Inpatient, or Outpatient Services |
| *One device every 36 months per ear* | |
| TMJ (Temporomandibular Joint) Services | See Professional, Inpatient, or Outpatient Services |
| *Up to $2,000/lifetime* | |
| **PRESCRIPTION DRUGS[3]** | |
| Prescription Drug List (formulary) | RxCore® |
| Prescription Drug Deductible - *Per Person* | $0 |
| Out-of-Pocket Maximum | Combined with medical |
| Prescription Drugs – *Up to a 30-day supply for covered medications* | |
| Tier 1 | $5 |
| Tier 2 | $30 |
| Tier 3 | 25% |
| Tier 4 | 50% |
| Tier 5 | 50% |
| Maintenance Drugs – *90-day supply (Mail-Order, Retail90®)* | |
| Tier 1 | $5 |
| 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 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 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.**
5. Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.
6. Select Health 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.
7. Select Health will cover an insulin from each therapeutic category with a cap of $25 per prescription of a 30-day supply.

*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.*