SMALL EMPLOYER MEMBER PAYMENT SUMMARY (MPS) UT 01/01/2025 S30C3555

Med Plus Gold 1000 Medical Deductible - no deductible for Rx

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

Select Health
MED NETWORK

	IN-NETWORK	OUT-OF-NETWORK
	When using In-Network Providers, you are responsible to pay the amounts in this column.	When using Out-of-Network Providers, you are responsible to pay the amounts in this column.
DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM[4,5]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar Year		
Deductible	$1,000	$3,000
Out-of-Pocket Maximum	$8,950	$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	$8,950/$17,900	$20,000/$40,000
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**	**OUT-OF-NETWORK**
Medical, Surgical, Hospice, Emergency Admissions	25% after Deductible	50% after Deductible
Hospital level care at home	25% after Deductible	Not Covered
Skilled Nursing Facility	25% after Deductible	50% after Deductible
Up to 60 days/calendar Year		
Rehab Therapy: Physical, Speech, Occupational	$40 after Deductible	50% after Deductible
Up to 40 days/calendar Year for all therapy types combined		
Physician's Fees - *Medical, Surgical, Maternity, Anesthesia*	25% after Deductible	50% after Deductible
PROFESSIONAL SERVICES[3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits and Office Surgeries		
Primary Care Provider (PCP)[1]	$20	50% after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100%	Not Covered
Specialist/Secondary Care Provider (SCP)[1]	$40	50% after Deductible
Allergy Tests	See office visits	Not Covered
Allergy Treatment and Serum	25%	Not Covered
Physician's Fees - *Surgical*	25% after Deductible	50% after Deductible
Physician's Fees - *Medical, Maternity, Anesthesia*	25% after Deductible	50% after Deductible
PREVENTIVE CARE AS OUTLINED BY THE ACA[2]	**IN-NETWORK**	**OUT-OF-NETWORK**
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	**IN-NETWORK**	**OUT-OF-NETWORK**
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	25% after Deductible	50% after Deductible
Limit one pair of eyeglass lenses or contact lenses per Year		
OUTPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility	25% after Deductible	50% after Deductible
Ambulatory Surgical Center	15% after Deductible	50% after Deductible
Imaging Center	$70 after Deductible	50% after Deductible
Ambulance (Air or Ground) - *emergencies only*	25% after Deductible	See In-Network Benefit
Emergency Room	$350 after Deductible	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$40	50% after Deductible
Intermountain KidsCare® Facilities	$20	Not Available
Intermountain Connect Care®	Covered 100%	Not Available
Radiation	25% after Deductible	50% after Deductible
Dialysis	25% after Deductible	50% after Deductible
Diagnostic Tests: Minor, per Provider	Covered 100%	50% after Deductible
Diagnostic Tests: Major, per Provider	25% after Deductible	50% after Deductible
Home Health[3]	25% after Deductible	50% after Deductible
Hospice[3]	25% after Deductible	50% after Deductible
Outpatient Cardiac Rehab	Covered 100%	50% after Deductible
Outpatient Private Nurse[3]	25% after Deductible	50% after Deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational	$25	50% after Deductible
Up to 20 visits/calendar Year for all therapy types combined		
Outpatient Habilitative Therapy: Physical, Speech, Occupational	$35	50% after Deductible
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**	**OUT-OF-NETWORK**
Maternity and Adoption[3,6] *Includes all related maternity and adoption services. Enroll in Select Health Healthy Beginnings Program® : 866-442-5052*	See Professional, Inpatient, or Outpatient Services	See Professional, Inpatient, or Outpatient Services
Chiropractic Care *Up to 10 visits/calendar Year*	$20	50% after Deductible
Miscellaneous Medical Supplies (MMS)[2]	25% after Deductible	50% 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
Durable Medical Equipment (DME)[3]	25% after Deductible	50% after Deductible
Prosthetic Devices[3]	25% after Deductible	50% after Deductible
Healthcare Provider Administered Injectable or Infusible Drugs[3]	50%	50% after Deductible
Chemotherapy[3]	50%	50% after Deductible
Infertility *(select services only)*	50% after Deductible	Not Covered
Pediatric Dental, Select Health Classic Network *(through 18 Years)* *Oral examinations and cleanings - two per calendar Year*	$40	Not Covered
Mental Health and Substance Use Disorder[3]		
Office Visits	$20	50% after Deductible
Virtual Visits	Covered 100%	50% after Deductible
Inpatient	25% after Deductible	50% after Deductible
Outpatient	25% after Deductible	50% after Deductible
Residential Treatment Center	25% after Deductible	50% after Deductible
Cochlear Implants or Auditory Osseointegrated Devices[3] *One device every 36 months per ear*	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)	RxCore®	
Prescription Drug Deductible - *Per Person*	$0	
Out-of-Pocket Maximum	Combined with medical	
Prescription Drugs – *Up to 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 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.

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.