HEALTHSAVE SHARE	01/01/2020

HEALTHSAVE PRODUCT

Administered by SelectHealth

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]	**IN-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar year	
Deductible	$1,500
Out-of-Pocket Maximum	$3,000
Family Coverage, 2 or more enrolled - per calendar year	
Deductible	$3,000
Out-of-Pocket Maximum	$6,000
(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	
PROFESSIONAL SERVICES	**IN-NETWORK**
Office Visits & Minor Office Surgeries	
Primary Care Provider (PCP)[1]	20% after deductible
Secondary Care Provider (SCP)[1]	20% 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	20% 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)*	20% after deductible
Emergency Room - *(Out-of-Network facility)*	20% after deductible
Intermountain InstaCare® Facilities, Urgent Care Facilities	20% after deductible
Intermountain KidsCare® Facilities	20% after deductible
Intermountain Connect Care®	Covered 100% after deductible
Chemotherapy, 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	20% after deductible

See other side for additional benefits

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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[4]	See Professional, Inpatient or Outpatient
Cochlear Implants[4]	See Professional, Inpatient or Outpatient
Infertility - *Selected Services* *(Max Plan Payment $1,500/ calendar year; $5,000 lifetime)*	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[4]	
Office Visits	20% after deductible
Inpatient	20% after deductible
Outpatient	20% after deductible
Residential Treatment[2]	20% after deductible
Injectable Drugs and Specialty Medications[4]	20% after deductible
Bariatric Surgery *(Up to one surgery/lifetime)* [4] *(Preauthorization is required. If preauthorization is not obtained, the bariatric services will not be covered. Must be enrolled on the Intermountain Healthcare Insurance plan for 2 consecutive years to be eligible).*	See Professional, Inpatient or Outpatient
Adoption Indemnity Benefits	$4,000

PRESCRIPTION DRUGS	INTERMOUNTAIN PHARMACY	NON-INTERMOUNTAIN PHARMACY
Prescription Drug List (formulary)	RxSelect®	
Prescription Drugs - *Up to 30 Day Supply of Covered Medications* [4]		
Tier 1	$10 after in-network deductible	$10 after in-network deductible
Tier 2	20% after in-network deductible	20% after in-network deductible
Tier 3	20% after in-network deductible	20% after in-network deductible
Tier 4	30% after in-network deductible	Not Covered
Maintenance Drugs-*90 Day Supply (Intermountain Pharmacies)-selected drugs* [4]		
Tier 1	$20 after in-network deductible	Not Covered
Tier 2	20% after in-network deductible	Not Covered
Tier 3	20% after in-network deductible	Not Covered
Tier 4	Not available for a 90 day supply	Not available for a 90 day supply
Preventive Prescription Drugs[3]-*Up to 30 Day Supply of Covered Medications* [4]		
Tier 1	$10	$10
Tier 2	20%	20%
Tier 3	20%	20%
Tier 4	30%	Not Covered
Preventive Maintenance Drugs[3]-*90 Day Supply (Intermountain Pharmacies)-selected drugs* [4]		
Tier 1	$20	Not Covered
Tier 2	20%	Not Covered
Tier 3	20%	Not Covered
Tier 4	Not available for a 90 day supply	Not available for a 90 day supply
Generic Substitution Required *Intermountain and Non-Intermountain Pharmacy Accumulate to the Participating Out-of-Pocket Maximum*	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 Health Insurance Handbook 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 your Health Insurance Handbook 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.

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.