Select Health Value Bronze $6900 Medical Deductible HSA Eligible

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

Select Health
VALUE NETWORK

	IN-NETWORK	OUT-OF-NETWORK
	You must use In-Network Providers (except for emergencies)	You must use In-Network Providers (except for emergencies)
DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM[4,5]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar Year		
Deductible	$6,900	N/A
Out-of-Pocket Maximum	$12,000	N/A
Family Coverage, 2 or more enrolled - per calendar Year		
Deductible - per person/family	$6,900/$13,800	N/A
Out-of-Pocket Maximum - per person/family	$12,000/$24,000	N/A
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	40% after Deductible	Not Covered
Skilled Nursing Facility	40% after Deductible	Not Covered
Up to 100 days/calendar Year		
Rehab/Habilitative Therapy: Physical, Speech, Occupational	40% after Deductible	Not Covered
Up to 60 days/calendar Year for all therapy types combined.		
Physician's Fees – *Medical, Surgical, Maternity, Anesthesia*	40% after Deductible	Not Covered
PROFESSIONAL SERVICES[3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits and Minor Office Surgeries		
Primary Care Provider (PCP)/OB/GYN[1]	$50 Copay for first 3 PCP office visits, then covered 100% after Deductible	Not Covered
Primary Care Provider (PCP)/OB/GYN Virtual Visits[1]	Covered 100%	Not Covered
Specialist/Secondary Care Provider (SCP)[1]	$90 after Deductible	Not Covered
Allergy Tests	See office visits	Not Covered
Allergy Treatment and Serum	40% after Deductible	Not Covered
Major Office Surgery	40% after Deductible	Not Covered
Physician's Fees – *Surgical*	40% after Deductible	Not Covered
Physician's Fees – *Medical, Maternity, Anesthesia*	40% after Deductible	Not Covered
PREVENTIVE SERVICES 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
Mental Health Wellness Exam	Covered 100%	Not Covered
Other Preventive Services/Preventive drugs	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]	Not Covered	Not Covered
All Other Eye Exams - Adult/Pediatric	$90 after Deductible	Not Covered
Contacts and Corrective Lenses - Through Age 18 Years, Only	$90 after Deductible	Not Covered
Limit one pair of eyeglasses or contact lenses per two Years		
OUTPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility and Ambulatory Surgical Center	40% after Deductible	Not Covered
Imaging Center	40% after Deductible	Not Covered
Ambulance (Air or Ground) - *emergencies only, applies to In-Network benefits*	40% after Deductible	See In-Network Benefit
Emergency Room - *applies to In-Network benefits*	40% after Deductible	See In-Network Benefit
Urgent Care Facilities	$65	See In-Network Benefit
UCHealth Virtual Urgent Care	Covered 100%	Not Covered
Intermountain Connect Care®	Covered 100%	Not Covered
Radiation	40% after Deductible	Not Covered
Dialysis	$90 after Deductible	Not Covered
Diagnostic Tests: Laboratory, per Provider	$50	Not Covered
Diagnostic Tests: Xrays and Minor, per Provider	10% after Deductible	Not Covered
Diagnostic Tests: Major, per Provider	40% after Deductible	Not Covered
Home Healthcare/Home Health Aide[3]	$90 after Deductible	Not Covered
Up to 28 hours/week, combined		
Hospice[3]	$90 after Deductible	Not Covered
Outpatient Cardiac Rehab	Covered 100%	Not Covered
Outpatient Private Nurse[3]	$90 after Deductible	Not Covered
Outpatient Rehab Therapy: Physical, Speech, Occupational	$90 after Deductible	Not Covered
Up to 20 visits/calendar Year per therapy type		
Outpatient Habilitative Therapy: Physical, Speech, Occupational	$90 after Deductible	Not Covered
Up to 20 visits/calendar Year per therapy type		

See next page for additional benefits and footnotes.

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Select Health VALUE NETWORK

	IN-NETWORK	OUT-OF-NETWORK
	You must use In-Network Providers (except for emergencies)	You must use In-Network Providers (except for emergencies)
MISCELLANEOUS SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Maternity[3]	See Professional, Inpatient, or Outpatient Services	Not Covered
Includes all related maternity services. Enroll in Select Health Healthy Beginnings Program® : 866-442-5052		
Chiropractic Care	$50	Not Covered
Up to 20 visits/calendar Year		
Acupuncture	$50	Not Covered
Up to 6 visits/calendar Year		
Gender Affirming Care	See Professional, Inpatient, Outpatient, or Mental Health and Substance Use Disorder Services	Not Covered
Miscellaneous Medical Supplies (MMS)[2]	40% after Deductible	Not Covered
Durable Medical Equipment (DME)[3]	40% after Deductible	Not Covered
Prosthetic Devices[3]	40% after Deductible	Not Covered
Prosthetic Devices: Arms and Legs[3]	20%	Not Covered
Nutritional Counseling	$90 after Deductible	Not Covered
Children's Early Intervention Services	Covered 100%	Not Covered
Healthcare Provider Administered Injectable or Infusible Drugs[3]	50% after Deductible	Not Covered
Transplant Services[3]	40% after Deductible	Not Covered
Diabetes Education	$90 after Deductible	Not Covered
Diabetes Supplies	40% after Deductible	Not Covered
Infusion Therapy	40% after Deductible	Not Covered
Reconstructive Surgery	40% after Deductible	Not Covered
Infertility (*select services only)*	40% after Deductible	Not Covered
Mental Health and Substance Use Disorder[3]		
Office Visits	$90 after Deductible	Not Covered
Virtual Office Visits	$50 Copay for first 3 visits, then covered 100% after Deductible	Not Covered
Inpatient	40% after Deductible	Not Covered
Outpatient[8]	40% after Deductible	Not Covered
Residential Treatment Center	40% after Deductible	Not Covered
Cochlear Implants or Hearing Aids[3]	See Professional, Inpatient, or Outpatient Services	Not Covered
One device every 60 months per ear		
TMJ (Temporomandibular Joint) Services	See Professional, Inpatient, or Outpatient Services	Not Covered
Bariatric Surgery[3]	See Professional, Inpatient, or Outpatient Services	Not Covered
PRESCRIPTION DRUGS[3,6]		
Prescription Drug List (formulary)	RxCore®	RxCore®
Prescription Drug Deductible - *Per Person*	Combined with medical	Combined with In-Network medical
Out-of-Pocket Maximum	Combined with medical	Combined with In-Network medical
Prescription Drugs – *Up to a 30-day supply for covered medications*		
Tier 1	Covered 100%	Covered 100%
Tier 2	$30	$30
Tier 3	$40	$40
Tier 4	$55 after Deductible	$55 after Deductible
Tier 5	50% after Deductible	50% after Deductible
Tier 6	50% after Deductible	50% after Deductible
Maintenance Drugs – *90-day supply (Mail-Order, Retail90®)*		
Tier 1	Covered 100%	Covered 100%
Tier 2	$60	$60
Tier 3	$100	$100
Tier 4	$165 after Deductible	Not Covered
Tier 5	50% after Deductible	Not Covered
Generic Substitution Required	Generic required or must pay Copay plus cost difference between name brand and generic	Generic required or must pay Copay plus cost difference between name brand and generic

As specified in § 10-16-161, C.R.S., effective for all health benefit plans issued or renewed on or after January 1, 2025, all carriers shall include any amount paid by the covered person and/or by another person on behalf of the covered person for a prescription drug when calculating the covered person's overall contribution to an out-of-pocket maximum or cost-sharing requirement.

FOOTNOTES

1. Visit **selecthealth.org/find-care** to find out whether a Provider is a Primary Care or Specialist/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. Insulin for the treatment of diabetes is subject to a maximum copay of $100 per 30-day prescription.
7. Select Health will cover a two-pack of Prescription epinephrine auto-injectors with a cap of $60.
8. Includes Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP), Transcranial Magnetic Stimulation (TMS), Applied Behavioral Analysis (ABA), and outpatient Electroconvulsive Treatment (ECT) (d) (e)

If a member is within 40 miles of an in-network urgent care provider and receives services from an out of network urgent care provider, the claim will process as out of network and the member may be balance billed. Emergency care is covered as in-network regardless of location.

Certain Preventive drugs are also available at no additional cost.

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.