**Select Health Value Gold $1500 Medical Deductible**

This is a Gold 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 | $1,500 | N/A |
| Out-of-Pocket Maximum | $9,500 | N/A |
| Family Coverage, 2 or more enrolled - per calendar Year | | |
| Deductible - per person/family | $1,500/$3,000 | N/A |
| Out-of-Pocket Maximum - per person/family | $9,500/$19,000 | 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 | 25% after Deductible | Not Covered |
| Skilled Nursing Facility | 25% after Deductible | Not Covered |
| *Up to 100 days/calendar Year* | | |
| Rehab/Habilitative Therapy: Physical, Speech, Occupational | 25% after Deductible | Not Covered |
| *Up to 60 days/calendar Year for all therapy types combined.* | | |
| Physician's Fees – *Medical, Surgical, Maternity, Anesthesia* | 25% 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] | $20 | Not Covered |
| Primary Care Provider (PCP)/OB/GYN Virtual Visits[1] | Covered 100% | Not Covered |
| Specialist/Secondary Care Provider (SCP)[1] | $50 | Not Covered |
| Allergy Tests | See office visits | Not Covered |
| Allergy Treatment and Serum | 25% | Not Covered |
| Major Office Surgery | 25% after Deductible | Not Covered |
| Physician's Fees – *Surgical* | 25% after Deductible | Not Covered |
| Physician's Fees – *Medical, Maternity, Anesthesia* | 25% 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 | $50 | Not Covered |
| Contacts and Corrective Lenses - Through Age 18 Years, Only | $50 | 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 | 25% after Deductible | Not Covered |
| Imaging Center | 25% after Deductible | Not Covered |
| Ambulance (Air or Ground) - *emergencies only, applies to In-Network benefits* | 25% after Deductible | See In-Network Benefit |
| Emergency Room - *applies to In-Network benefits* | 25% after Deductible | See In-Network Benefit |
| Urgent Care Facilities | $40 | See In-Network Benefit |
| UCHealth Virtual Urgent Care | Covered 100% | Not Covered |
| Intermountain Connect Care® | Covered 100% | Not Covered |
| Radiation | 25% after Deductible | Not Covered |
| Dialysis | $50 | Not Covered |
| Diagnostic Tests: Laboratory, per Provider | $10 | Not Covered |
| Diagnostic Tests: Xrays and Minor, per Provider | 5% after Deductible | Not Covered |
| Diagnostic Tests: Major, per Provider | 25% after Deductible | Not Covered |
| Home Healthcare/Home Health Aide[3] | $50 | Not Covered |
| *Up to 28 hours/week, combined* | | |
| Hospice[3] | $50 | Not Covered |
| Outpatient Cardiac Rehab | Covered 100% | Not Covered |
| Outpatient Private Nurse[3] | $50 | Not Covered |
| Outpatient Rehab Therapy: Physical, Speech, Occupational | $50 after Deductible | Not Covered |
| *Up to 20 visits/calendar Year per therapy type* | | |
| Outpatient Habilitative Therapy: Physical, Speech, Occupational | $50 after Deductible | Not Covered |
| *Up to 20 visits/calendar Year per therapy type* | | |



*See next page for additional benefits and footnotes.*

**Select Health Value Gold $1500 Medical Deductible**

This is a Gold 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) |
| **MISCELLANEOUS SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| Maternity[3]<br>*Includes all related maternity services. Enroll in Select Health Healthy Beginnings Program® : 866-442-5052* | See Professional, Inpatient, or Outpatient Services | Not Covered |
| Chiropractic Care<br>*Up to 20 visits/calendar Year* | $20 | Not Covered |
| Acupuncture<br>*Up to 6 visits/calendar Year* | $20 | Not Covered |
| Gender Affirming Care | See Professional, Inpatient, Outpatient, or Mental Health and Substance Use Disorder Services | Not Covered |
| Miscellaneous Medical Supplies (MMS)[2] | 25% after Deductible | Not Covered |
| Durable Medical Equipment (DME)[3] | 25% after Deductible | Not Covered |
| Prosthetic Devices[3] | 25% after Deductible | Not Covered |
| Prosthetic Devices: Arms and Legs[3] | 20% | Not Covered |
| Nutritional Counseling | $50 | 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] | 25% after Deductible | Not Covered |
| Diabetes Education | $50 | Not Covered |
| Diabetes Supplies | 25% after Deductible | Not Covered |
| Infusion Therapy | 25% after Deductible | Not Covered |
| Reconstructive Surgery | 25% after Deductible | Not Covered |
| Infertility (*select services only)* | 25% after Deductible | Not Covered |
| Mental Health and Substance Use Disorder[3] | | |
| Office Visits | $50 | Not Covered |
| Virtual Office Visits | $20 | Not Covered |
| Inpatient | 25% after Deductible | Not Covered |
| Outpatient[8] | 25% after Deductible | Not Covered |
| Residential Treatment Center | 25% after Deductible | Not Covered |
| Cochlear Implants or Hearing Aids[3]<br>*One device every 60 months per ear* | See Professional, Inpatient, or Outpatient Services | Not Covered |
| 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® |
| | Individual/Family | Individual/Family |
| Prescription Drug Deductible | $900/$2,700 | Combined with In-Network Pharmacy Deductible |
| 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 | $10 | $10 |
| Tier 3 | $25 | $25 |
| Tier 4 | 25% after pharmacy Deductible | 25% after pharmacy Deductible |
| Tier 5 | 50% after pharmacy Deductible | 50% after pharmacy Deductible |
| Tier 6 | 50% after pharmacy Deductible | 50% after pharmacy Deductible |
| Maintenance Drugs – *90-day supply (Mail-Order, Retail90® )* | | |
| Tier 1 | Covered 100% | Covered 100% |
| Tier 2 | $20 | $20 |
| Tier 3 | $62.50 | $62.50 |
| Tier 4 | 25% after pharmacy Deductible | Not Covered |
| Tier 5 | 50% after pharmacy 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.*