selecthealth

SELECTHEALTH NETWORK / 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.	OUT-OF-NETWORK When using out-of-network providers, you are responsible to pay the amounts in this column.
CONDITIONS AND LIMITATIONS		
Lifetime Maximum Plan Payment - *Per Person*	None	
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	plan year	
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per plan year		
Deductible	$1,500	
Out-of-Pocket Maximum	$4,000	None
Family Coverage, 2 or more enrolled - per plan year		
Deductible	$3,000	
Out-of-Pocket Maximum - per person/family	$4,000/$8,000	None
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical and Hospice[4]	20% after Deductible	40% after Deductible
Skilled Nursing Facility[4] - Up to 30 days per plan year	20% after Deductible	40% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after Deductible	40% after Deductible
PROFESSIONAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits		
Primary Care Provider (PCP)[1]	20% after Deductible	40% after Deductible
Secondary Care Provider (SCP)[1]	20% after Deductible	40% after Deductible
Mental Health Office Visits	20% after Deductible	40% after Deductible
Allergy Tests	20% after Deductible	40% after Deductible
Allergy Treatment and Serum	20% after Deductible	40% after Deductible
Medical and Surgical Professional Services[4]		
Primary Care Provider (PCP)[1]	20% after Deductible	40% after Deductible
Secondary Care Provider (SCP)[1]	20% after Deductible	40% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	Not Covered
Secondary Care Provider (SCP)[1]	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	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**
Preventive Eye Exams	Administered by VSP	Not Covered
All Other Eye Exams	20% after Deductible	40% after Deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility and Ambulatory Surgical	20% after Deductible	40% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after Deductible	See In-Network Benefit
Ambulance (Air or Ground) - *Inter-facility Transfers*[4]	Covered 100% after Deductible	See In-Network Benefit
Emergency Room - *Facility and Physician*	20% after Deductible	See In-Network Benefit
Emergency Room - *Diagnostic Tests*	20% after Deductible	See In-Network Benefit
Urgent Care Facilities	20% after Deductible	40% after Deductible
Chemotherapy, Radiation and Dialysis	20% after Deductible	40% after Deductible
Diagnostic Tests: Minor[2]	20% after Deductible	40% after Deductible
Diagnostic Tests: Major[2]	20% after Deductible	40% after Deductible
Home Health, Hospice, Outpatient Private Nurse	20% after Deductible	40% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	20% after Deductible	40% after Deductible

See other side for additional benefits

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SCHEDULE OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
MISCELLANEOUS SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME)[4]	20% after Deductible	40% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after Deductible	40% after Deductible
Maternity[4]	See Professional, Inpatient or Outpatient	40% after Deductible
Cochlear Implants[4] - *Up to $100,000 lifetime*	20% after Deductible	40% after Deductible
Hearing Aids or Auditory Osseointegrated Devices[4] *One device every 36 months per ear. Up to 45 language/speech therapy visits during the 12 months after the delivery of the covered device.*	See Professional, Inpatient or Outpatient	50% after Deductible
Infertility - *Select Services*	Not Covered	Not Covered
Donor Fees for Covered Organ Transplants[2,4]	20% after Deductible	40% after Deductible
Transplant Travel Expenses - *Up to $10,000 for Donor and Recipient*	Covered 100%	
TMJ (Temporomandibular Joint) Services - *Up to $1,000 annual max*	20% after Deductible	40% after Deductible
Chiropractic - *Up to $600 per participant per plan year*	20% after Deductible	40% after Deductible
Injectable Drugs and Specialty Medications[4]	20% after Deductible	40% after Deductible
Bariatric Surgery - *Only at St. Luke's Hospital, Limited to 1 per lifetime*[2,4] *(Preauthorization is required. If preauthorization is not obtained, the bariatric services will not be covered.)*	*$2,000 copay, then 20% after Deductible	Not Covered
OPTIONAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Chemical Dependency[4] *(combined benefits)*		
Office Visits	See Professional Services	See Professional Services
Inpatient[4]	20% after Deductible	40% after Deductible
Outpatient[4]	20% after Deductible	40% after Deductible
Residential Treatment[2]	20% after Deductible	40% after Deductible
Diabetes Self-Management Education Services - *Up to $500 per plan year*	20% after Deductible	40% after Deductible
PRESCRIPTION DRUGS		
Prescription Drugs - *Not Administered by SelectHealth* Administered by St. Luke's PBM: *1-877-203-3358*	Not Covered	

1 Refer to **selecthealth.org/findadoctor** to identify whether a provider is a primary or secondary care Provider.

2 Refer to your Summary Plan Description 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 Section 11--" Healthcare Management", in your Summary Plan Description, 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.

6 Certain Services as noted on this document and in your Summary Plan Description are not subject to the Deductible.

* Not applied to Medical out-of-pocket maximum.

All Covered Services obtained outside the United States, except for routine, Urgent, or Emergency conditions require preauthorization.

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.