PAYMENT SUMMARY-INDIVIDUAL PLAN

ID 06/01/2026 I33G0002

Select Health

MED NETWORK

	SEE ANY PROVIDER
	You are responsible to pay the amounts in this column. When you use Out-of-Network providers, you are also responsible for amounts exceeding the allowed amount.
CONDITIONS AND LIMITATIONS	
Lifetime Maximum Plan Payment - *Per Person*	$1,000,000
Pre-Existing Conditions (PEC)[2]	Not covered
PLAN TERM DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM	**INDIVIDUAL/FAMILY**
Deductible - *Per calendar Year*	$4,000/$8,000
Out-of-Pocket Maximum - *Per Person* *This amount is your Deductible + your Coinsurance and Copay (medical and Rx)*	$4,600
INPATIENT FACILITY SERVICES[1]	**YOU PAY**
Inpatient facility services include medical and surgical hospital admissions, skilled nursing facilities, rehabilitation therapy, and all associated physician's fees incurred while inpatient *Skilled nursing facility services are limited to 40 days per plan term* *Inpatient rehabilitation therapy services are limited to 30 days per plan term*	50% after deductible
OFFICE SERVICES[1]	**YOU PAY**
Office services include office visits, office surgeries, diagnostic tests (X-rays, blood tests, etc.), allergy tests, allergy treatment and serum, and associated services.	50% after deductible
Primary Care Provider (PCP) Virtual Visits	$70 (Limit of 2 visits per term per member. Deductible/Coinsurance apply thereafter.)
Intermountain Connect Care®	$70
OUTPATIENT FACILITY SERVICES[1]	**YOU PAY**
Outpatient facility services include outpatient surgeries, Emergency room visits, diagnostic tests (MRIs, CT scans, etc.), outpatient rehabilitation therapy, and associated physician's fees incurred for outpatient procedures. *Outpatient rehabilitation therapy services are limited to 20 visits per each therapy type (Physical, occupational, and speech therapy) per plan term*	50% after deductible
MISCELLANEOUS SERVICES[1]	**YOU PAY**
Miscellaneous services include transportation by ambulance in the case of emergency, home health and private duty nursing, Durable Medical Equipment (DME)[2], miscellaneous medical supplies[3], injectable drugs[1], chiropractic care, and other covered services that do not fall under the above categories. *Chiropractic care limited to 5 visits per plan term*	50% after deductible
NONCOVERED SERVICES	
NonCovered Services include, but are not limited to, maternity, adoption, preventive care, immunizations, infertility treatment and services, mental health, and substance use disorder. Please refer to your Contract for complete coverage and exclusion information.	Not Covered
PRESCRIPTION DRUGS[4]	**GENERIC ONLY (BRANDS NOT COVERED)**
Prescription Drug List (formulary)	RxBasic®
Prescription Drug Deductible - *Per Person per Calendar Year*	$2,000
Prescription Drugs - *Up to 30-day supply for covered medications*	
Tier 1	$10
Tier 2	$35 after pharmacy Deductible
Tier 3	25% after pharmacy Deductible
Tier 4	50% after pharmacy Deductible
Tier 5	50% after pharmacy Deductible
Maintenance Drugs - *90-day supply*	Not Covered

FOOTNOTES

1. When you use Out-of-Network providers (providers who do not participate on the Select Health network), you are responsible to preauthorize the following services: inpatient services, home health and nursing services, pain management services, DME, and certain injectable drugs. Benefits may be reduced or denied if you do not preauthorize certain services. Please refer to Section 10 – "Healthcare Management," in your Contract for details.

2. A Pre-Existing Condition exists when medical advice, diagnosis, care, or treatment (including prescription and over-the-counter medication recommended by a Provider) was either received from or recommended by a Provider during the six-month period prior to the Enrollment Date.

3. Frequency and/or quantity limitations apply 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 Certificate of Coverage, for details.

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 Select Health pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

PAYMENT SUMMARY-INDIVIDUAL PLAN — ID 06/01/2026 I33G0001

Select Health
MED NETWORK

	SEE ANY PROVIDER
	You are responsible to pay the amounts in this column. When you use Out-of-Network providers, you are also responsible for amounts exceeding the allowed amount.
CONDITIONS AND LIMITATIONS	
Lifetime Maximum Plan Payment - *Per Person*	$1,000,000
Pre-Existing Conditions (PEC)[2]	Not covered
PLAN TERM DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM	**INDIVIDUAL/FAMILY**
Deductible - *Per calendar Year*	$2,500/$5,000
Out-of-Pocket Maximum - *Per Person*	$5,000
This amount is your Deductible + your Coinsurance and Copay (medical and Rx)	
INPATIENT FACILITY SERVICES[1]	**YOU PAY**
Inpatient facility services include medical and surgical hospital admissions, skilled nursing facilities, rehabilitation therapy, and all associated physician's fees incurred while inpatient	20% after deductible
Skilled nursing facility services are limited to 40 days per plan term	
Inpatient rehabilitation therapy services are limited to 30 days per plan term	
OFFICE SERVICES[1]	**YOU PAY**
Office services include office visits, office surgeries, diagnostic tests (X-rays, blood tests, etc.), allergy tests, allergy treatment and serum, and associated services.	20% after deductible
Primary Care Provider (PCP) Virtual Visits	$70 (Limit of 2 visits per term per member. Deductible/Coinsurance apply thereafter.)
Intermountain Connect Care®	$70
OUTPATIENT FACILITY SERVICES[1]	**YOU PAY**
Outpatient facility services include outpatient surgeries, Emergency room visits, diagnostic tests (MRIs, CT scans, etc.), outpatient rehabilitation therapy, and associated physician's fees incurred for outpatient procedures.	20% after deductible
Outpatient rehabilitation therapy services are limited to 20 visits per each therapy type (Physical, occupational, and speech therapy) per plan term	
MISCELLANEOUS SERVICES[1]	**YOU PAY**
Miscellaneous services include transportation by ambulance in the case of emergency, home health and private duty nursing, Durable Medical Equipment (DME)[2], miscellaneous medical supplies[3], injectable drugs[1], chiropractic care, and other covered services that do not fall under the above categories.	20% after deductible
Chiropractic care limited to 5 visits per plan term	
NONCOVERED SERVICES	
NonCovered Services include, but are not limited to, maternity, adoption, preventive care, immunizations, infertility treatment and services, mental health, and substance use disorder. Please refer to your Contract for complete coverage and exclusion information.	Not Covered
PRESCRIPTION DRUGS[4]	**GENERIC ONLY (BRANDS NOT COVERED)**
Prescription Drug List (formulary)	RxBasic®
Prescription Drug Deductible - *Per Person per Calendar Year*	$2,000
Prescription Drugs - *Up to 30-day supply for covered medications*	
Tier 1	$10
Tier 2	$35 after pharmacy Deductible
Tier 3	25% after pharmacy Deductible
Tier 4	50% after pharmacy Deductible
Tier 5	50% after pharmacy Deductible
Maintenance Drugs - *90-day supply*	Not Covered

FOOTNOTES

1. When you use Out-of-Network providers (providers who do not participate on the Select Health network), you are responsible to preauthorize the following services: inpatient services, home health and nursing services, pain management services, DME, and certain injectable drugs. Benefits may be reduced or denied if you do not preauthorize certain services. Please refer to Section 10 – "Healthcare Management," in your Contract for details.

2. A Pre-Existing Condition exists when medical advice, diagnosis, care, or treatment (including prescription and over-the-counter medication recommended by a Provider) was either received from or recommended by a Provider during the six-month period prior to the Enrollment Date.

3. Frequency and/or quantity limitations apply 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 Certificate of Coverage, for details.

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 Select Health pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.