

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**


**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [selecthealth.org](http://selecthealth.org) or by calling 800-538-5038. For a copy of the Uniform Glossary visit [selecthealth.org/sbc](http://selecthealth.org/sbc).

| Important Questions                                       | Answers                                                                                                                                                                                       | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <b>deductible</b> ?                   | <b>\$1,500</b> single. Does not apply to preventive care. Copays and co-insurance do not apply towards the <b>deductible</b> .                                                                | You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .                                                                                             |
| Are there other <b>deductibles</b> for specific services? | No.                                                                                                                                                                                           | You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.                                                                                                                                                                                                                                                                                                              |
| Is there an <b>out-of-pocket limit</b> on my expenses?    | Yes. <b>\$5,000</b> single.                                                                                                                                                                   | The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.                                                                                                                                                                                                                                                          |
| What is not included in the <b>out-of-pocket limit</b> ?  | Premiums, balance-billed charges, healthcare this plan doesn't cover, and penalties for failure to obtain pre-authorization for services.                                                     | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .                                                                                                                                                                                                                                                                                                                                                                      |
| Is there an overall annual limit on what the plan pays?   | No.                                                                                                                                                                                           | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.                                                                                                                                                                                                                                                                                                                          |
| Does this plan use a <b>network of providers</b> ?        | Yes. To find a participating Select Care <sup>SM</sup> provider visit <a href="http://selecthealth.org/findadoctor">selecthealth.org/findadoctor</a> or call Member Services at 800-538-5038. | If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |
| Do I need a referral to see a <b>specialist</b> ?         | No.                                                                                                                                                                                           | You can see the <b>specialist</b> you choose without permission from this plan.                                                                                                                                                                                                                                                                                                                                                                                   |
| Are there services this plan doesn't cover?               | Yes.                                                                                                                                                                                          | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b> .                                                                                                                                                                                                                                                                                                   |

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If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [selecthealth.org/sbc](http://selecthealth.org/sbc) or call 800-538-5038 to request a copy.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event                                          | Services You May Need                                  | Your cost if you use |                   | Limitations & Exceptions                                           |
|---------------------------------------------------------------|--------------------------------------------------------|----------------------|-------------------|--------------------------------------------------------------------|
|                                                               |                                                        | Participating        | Non-Participating |                                                                    |
| If you visit a health care <b>provider's</b> office or clinic | Primary care visit to treat an injury or illness (PCP) | \$25/visit           | Not covered       | -----None-----                                                     |
|                                                               | Specialist visit (SCP)                                 | \$40/visit           | Not covered       | Certain limitations apply to allergy testing, treatment and serum. |
|                                                               | Other practitioner office visit                        | Not covered          | Not covered       | Chiropractic and acupuncture not covered.                          |
|                                                               | Preventive care / screening / immunization             | No charge            | Not covered       | Frequency limitations apply. Deductible does not apply.            |
| If you have a test                                            | Diagnostic test (x-ray, blood work)                    | No charge            | Not covered       | -----None-----                                                     |
|                                                               | Imaging (CT/PET scans, MRIs)                           | 20% co-insurance     | Not covered       | -----None-----                                                     |

| Common Medical Event                                                                                                                                                              | Services You May Need                          | Your cost if you use |                   | Limitations & Exceptions                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                   |                                                | Participating        | Non-Participating |                                                                                                                                                    |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b><u>prescription drug coverage</u></b> is available at <b><u>selecthealth.org</u></b> | Standard Tier 1                                | \$10/prescription    | \$10/prescription | Certain limitations apply. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.                   |
|                                                                                                                                                                                   | Standard Tier 2                                | 25% co-insurance     | 25% co-insurance  |                                                                                                                                                    |
|                                                                                                                                                                                   | Standard Tier 3                                | 50% co-insurance     | 50% co-insurance  |                                                                                                                                                    |
|                                                                                                                                                                                   | Maintenance Tier 1                             | \$10/prescription    | \$10/prescription |                                                                                                                                                    |
|                                                                                                                                                                                   | Maintenance Tier 2                             | 25% co-insurance     | 25% co-insurance  |                                                                                                                                                    |
|                                                                                                                                                                                   | Maintenance Tier 3                             | 50% co-insurance     | 50% co-insurance  | Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.                                              |
|                                                                                                                                                                                   | Specialty drugs                                | 20% co-insurance     | Not covered       |                                                                                                                                                    |
| <b>If you have outpatient surgery</b>                                                                                                                                             | Facility fee (e.g., ambulatory surgery center) | 20% co-insurance     | Not covered       | -----None-----                                                                                                                                     |
|                                                                                                                                                                                   | Physician/surgeon fees                         | 20% co-insurance     | Not covered       | -----None-----                                                                                                                                     |
| <b>If you need immediate medical attention</b>                                                                                                                                    | Emergency room services                        | \$250/visit          | \$250/visit       | Emergency room services apply to participating benefits.                                                                                           |
|                                                                                                                                                                                   | Emergency medical transportation               | 20% co-insurance     | 20% co-insurance  | Emergencies only. Emergency medical transportation applies to participating benefits.                                                              |
|                                                                                                                                                                                   | Urgent care                                    | \$40/visit           | Not covered       | Applies to urgent care facilities only.                                                                                                            |
| <b>If you have a hospital stay</b>                                                                                                                                                | Facility fee (e.g., hospital room)             | 20% co-insurance     | Not covered       | Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.                                              |
|                                                                                                                                                                                   | Physician/surgeon fee                          | 20% co-insurance     | Not covered       |                                                                                                                                                    |
| <b>If you have mental health, behavioral health, or substance abuse needs</b>                                                                                                     | Mental/Behavioral health outpatient services   | 20% co-insurance     | Not covered       | Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services. Additional limitations and exclusions apply. |
|                                                                                                                                                                                   | Mental/Behavioral health inpatient services    | 20% co-insurance     | Not covered       |                                                                                                                                                    |
|                                                                                                                                                                                   | Substance use disorder outpatient services     | 20% co-insurance     | Not covered       |                                                                                                                                                    |
|                                                                                                                                                                                   | Substance use disorder inpatient services      | 20% co-insurance     | Not covered       |                                                                                                                                                    |

| Common Medical Event                                           | Services You May Need               | Your cost if you use                                         |                   | Limitations & Exceptions                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                     | Participating                                                | Non-Participating |                                                                                                                                                                                                                                                                                                                             |
| If you are pregnant                                            | Prenatal and postnatal care         | 20% co-insurance                                             | Not covered       | Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.                                                                                                                                                                                                                       |
|                                                                | Delivery and all inpatient services | 20% co-insurance                                             | Not covered       |                                                                                                                                                                                                                                                                                                                             |
| If you need help recovering or have other special health needs | Home health care                    | 20% co-insurance                                             | Not covered       | Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.                                                                                                                                                                                                                       |
|                                                                | Rehabilitation services             | \$40/visit for outpatient and 20% co-insurance for inpatient | Not covered       | Up to 20 days per calendar year for each therapy type for outpatient physical, speech, and occupational therapy. Up to 40 days per calendar year for inpatient physical, speech, and occupational therapies combined. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services. |
|                                                                | Habilitation services               | \$40/visit                                                   | Not covered       | Subject to outpatient rehabilitation limits. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.                                                                                                                                                                          |
|                                                                | Skilled nursing care                | 20% co-insurance                                             | Not covered       | Up to 60 days per calendar year. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.                                                                                                                                                                                      |
|                                                                | Durable medical equipment (DME)     | 20% co-insurance                                             | Not covered       | For certain DME, benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.                                                                                                                                                                                                      |
|                                                                | Hospice service                     | 20% co-insurance                                             | Not covered       | Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.                                                                                                                                                                                                                       |
| If your child needs dental or eye care                         | Eye exam                            | \$40/visit                                                   | Not covered       | -----None-----                                                                                                                                                                                                                                                                                                              |
|                                                                | Glasses                             | 20% co-insurance                                             | Not covered       | Corrective lenses for children through age 18, one set per year. Eyeglass frames are not covered.                                                                                                                                                                                                                           |
|                                                                | Dental check-up                     | Not covered                                                  | Not covered       | Dental check-ups are not covered.                                                                                                                                                                                                                                                                                           |

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Abortions/termination of pregnancy except in limited circumstances</li> <li>• Acupuncture</li> <li>• Administrative services/charges</li> <li>• Attention-Deficit/Hyperactivity Disorder/Pervasive Development Disorder</li> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> <li>• Complications of a non-covered service for the 1st year after the original date of service</li> <li>• Cosmetic surgery and reconstructive and corrective services, except in limited circumstances</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (adult/child), except in limited circumstances</li> <li>• Dental check-up</li> <li>• Experimental and/or investigational services</li> <li>• Eyeglass frames</li> <li>• Hearing aids</li> <li>• Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever</li> <li>• Infertility (select services) greater than \$1,500 per year and \$5,000 per lifetime</li> <li>• Infertility treatment</li> <li>• Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S., except for urgent care</li> <li>• Organ donor fees without preauthorization</li> <li>• Orthognathic services</li> <li>• Orthotic and other corrective appliances for the foot</li> <li>• Services for which a third-party is or may be responsible</li> <li>• Services related to certain illegal activities</li> <li>• Services that are not medically necessary</li> <li>• Temporomandibular Joint (TMJ) services</li> </ul> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

|                                                                                                                      |                                                                                                           |                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Private Duty Nursing, requires preauthorization with limitations</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> </ul> | <ul style="list-style-type: none"> <li>• Weight loss programs as part of a program approved by SelectHealth</li> </ul> |
|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact SelectHealth at 800-538-5038. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or [dol.gov/ebsa](http://dol.gov/ebsa), or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or [cciio.cms.gov](http://cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Member Services at 800-538-5038. You may also contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform). If your coverage is fully-insured, you may also contact the Utah Insurance Department, Office of Consumer Assistance, Suite 3110, State Office Building, Salt Lake City, Utah 84114. For additional information about your grievance and appeals rights, see your Member Materials.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 800-538-5038.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby

(normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,820
- Patient pays \$2,720

#### Sample care costs:

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$1,500        |
| Co-pays              | \$20           |
| Co-insurance         | \$1,050        |
| Limits or exclusions | \$150          |
| <b>Total</b>         | <b>\$2,720</b> |

### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,180
- Patient pays \$2,220

#### Sample care costs:

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$1,500        |
| Co-pays              | \$460          |
| Co-insurance         | \$180          |
| Limits or exclusions | \$80           |
| <b>Total</b>         | <b>\$2,220</b> |

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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