



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 or by calling 800-538-5038. For a copy of the Uniform Glossary, visit selecthealth.org/sbc or call 800-538-5038.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Participating options (calendar year): \$500 person/\$1,500 family; \$1,000 person/\$2,500 family; \$2,500 person/\$5,000 family; \$5,000 person/\$10,000 family; \$7,500 person/\$15,000 family Nonparticipating options (calendar year): \$750 person/\$2,250 family; \$1,500 person/\$3,500 family; \$3,000 person/\$6,000 family; \$6,000 person/\$12,000 family; \$8,500 person/\$17,000 family Copays and co-insurance do not apply to the <u>deductible</u>. <u>Deductible</u> does not apply to preventive services, prescription drugs, or office visits (if office visit <u>deductible</u> waiver is elected).	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u>.
Are there other <u>deductibles</u> for specific services?	Yes. \$7,500 per pregnancy or adoption. Prescription drug deductible options: \$250 person; \$500 person; \$1,000 person; \$2,000 person There are no other specific <u>deductibles</u>.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. Participating options: \$3,000 person/\$6,000 family; \$3,500 person/\$7,000 family; \$4,000 person/\$8,000 family; \$6,500 person/\$13,000 family; \$9,000 person/\$18,000 family Nonparticipating options: \$5,000 person/\$10,000 family; \$5,500 person/\$11,000 family; \$8,000 person/\$16,000 family; \$10,000 person/\$20,000 family; \$12,000 person/\$24,000 family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, maternity, mental health, prescription drugs, penalties for failure to obtain pre-authorization for services, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.

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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 network of providers?	Yes. To find a participating provider visit selecthealth.org/findadoctor or call Member Services at 800-538-5038.	If you use an in-network doctor or other health care provider , 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 provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No	You can see the specialist 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 excluded services .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Participating Provider	Nonparticipating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25/visit	Not covered	Deductible waived if office visit deductible waiver is elected.
	Specialist visit	\$40/visit	Not covered	Certain limitations apply to allergy testing, treatment, and serum.
	Other practitioner office visit	Not covered	Not covered	Acupuncture and chiropractic care are not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Participating Provider	Nonparticipating Provider	
	Preventive care/screening/immunization	No charge	Not covered	Deductible does not apply. Frequency limitations apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Deductible waived if office visit deductible waiver is elected.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	-----None-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <u>selecthealth.org</u>	Standard Tier 1	\$10/prescription	\$10/prescription	Certain limitations apply. Pharmacy deductible applies except to tier 1 drugs. Benefits may be reduced or denied 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	
	Specialty drugs	20% co-insurance	20% co-insurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	Not covered	-----None-----
	Physician/surgeon fees	20% co-insurance	Not covered	
If you need immediate medical attention	Emergency room services	\$250/visit	\$250/visit	-----None-----
	Emergency medical transportation	20% co-insurance	20% co-insurance	Emergencies only.
	Urgent care	\$40/visit	\$40/visit	Applies to urgent care facilities only.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	Not covered	Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services.
	Physician/surgeon fee	20% co-insurance	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	50% co-insurance	Not covered	Certain limitations apply. Up to 25 visits/calendar year for outpatient services. Up to 10 visits/calendar year for inpatient services. Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services.
	Mental/Behavioral health inpatient services	50% co-insurance	Not covered	
	Substance use disorder outpatient services	50% co-insurance	Not covered	
	Substance use disorder inpatient services	50% co-insurance	Not covered	
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Applies to separate \$7,500 maternity deductible.
	Delivery and all inpatient services	No charge	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Participating Provider	Nonparticipating Provider	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	Not covered	Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services
	Rehabilitation services	\$40/visit or 20% co-insurance	Not covered	Up to 20 visits/calendar year for outpatient physical, occupational, and speech therapy. Up to 40 days/calendar year for inpatient physical, occupational, and speech therapy combined. Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services.
	Habilitation services	Not covered	Not covered	Habilitation is not covered.
	Skilled nursing care	20% co-insurance	Not covered	Up to 60 visits/calendar year. Benefits may be reduced or denied 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 reduced or denied by 50% for failure to obtain preauthorization.
	Hospice service	20% co-insurance	Not covered	Benefits may be reduced or denied 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	Not covered	Not covered	Glasses 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.)

- Abortions/terminations of pregnancy, except in limited circumstances
- Acupuncture
- Administrative services
- Attention-Deficit/Hyperactivity Disorder/Pervasive Developmental Disorder
- Bariatric surgery
- Certain services while in a waiting period or a pre-existing condition period
- Chiropractic care
- Complications for a non-covered service
- Cosmetic surgery/services and reconstructive and corrective services, except in limited circumstances
- Dental care (adult/child), except in limited circumstances
- Dental check-ups
- Experimental and/or investigational services
- Glasses
- Habilitation services
- Hearing aids
- Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid, and Yellow Fever
- Infertility treatment
- Long-term care
- Organ donor fees greater than \$60,000/transplant – requires preauthorization
- Orthognathic services
- Orthotics and other corrective appliances for the foot
- Temporomandibular Joint Disorder (TMJ)
- Services for which a third-party is or may be responsible
- Services that are not medically necessary
- Services related to certain illegal activities

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.)

- Private Duty Nursing – requires preauthorization with limitations
- Routine eye care
- Routine foot care
- Weight loss programs as part of a program approved by SelectHealth

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 800-538-5038. You may also contact your state insurance department at Utah Insurance Department, Office of Consumer Assistance, Suite 3110, State Office Building, Salt Lake City, Utah 84114.

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 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.

Language Access Services:

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo 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 \$0
- Patient pays \$7,540

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
Total	\$7,540

Patient pays:

Deductibles	\$7,390
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$7,540

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,970
- Patient pays \$1,430

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
Total	\$5,400

Patient pays:

Deductibles	\$500
Copays	\$380
Coinsurance	\$470
Limits or exclusions	\$80
Total	\$1,430

Note: coverage examples are based on a plan with a \$500 medical deductible, \$3,000 out-of-pocket maximum, and a \$250 prescription drug deductible.

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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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