selecthealth **BEAR RIVER HEAD START**

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

Coverage Period: 12/01/2015 - 11/30/2016
Coverage for: Single/Family | Plan Type: POS

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.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** person/**$2,000** family participating and **$2,000** person/**$4,000** family non-participating per calendar year. Does not apply to office visits, preventive services or prescription drugs. Copays and co-insurance do not apply towards the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	Yes. **$200** per person for prescription drugs. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,000** person/**$6,000** family participating and **$6,000** person/**$12,000** family non-participating.	The **out-of-pocket limit** 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 out–of–pocket limit?	Premiums, balance-billed charges, infertility services, 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 **out-of-pocket limit**.
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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. To find a participating Select Care Plus℠ 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**.

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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 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 provider's office or clinic	Primary care visit to treat an injury or illness (PCP)	$25/visit	40% co-insurance	A different benefit may apply for major office surgery over $350. Deductible does not apply to participating services.
	Specialist visit (SCP)	$40/visit	40% co-insurance	Certain limitations apply to allergy testing, treatment and serum. A different benefit may apply for major office surgery over $350. Deductible does not apply to participating services.
	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 to participating services.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% co-insurance	Deductible does not apply to participating services.
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	----------None----------

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Participating	Non-Participating	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **selecthealth.org**	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. Pharmacy deductible waived for tier 1.
	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 for medical, 20% co-insurance for pharmacy	40% co-insurance for medical, 20% co-insurance for pharmacy	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	----------None----------
	Physician/surgeon fees	20% co-insurance	40% co-insurance	----------None----------
If you need immediate medical attention	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	40% co-insurance	Applies to urgent care facilities only. Deductible does not apply to participating services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 for office visits, 20% co-insurance for outpatient	40% co-insurance for office visits, 40% co-insurance for outpatient	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services. Additional limitations and exclusions apply. Deductible does not apply to participating office visits and outpatient services.
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	
	Substance use disorder outpatient services	$25 for office visits, 20% co-insurance for outpatient	40% co-insurance for office visits, 40% co-insurance for outpatient	
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	

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	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Rehabilitation services	$40/visit for outpatient, 20% co-insurance for inpatient	40% co-insurance	Up to 20 visits 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	Not covered	Not covered	Habilitation is not covered.
	Skilled nursing care	20% co-insurance	40% co-insurance	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	40% co-insurance	For certain DME, benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Hospice service	20% co-insurance	40% co-insurance	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	40% co-insurance	Deductible does not apply to participating services.
	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/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • Attention-Deficit/Hyperactivity Disorder/Pervasive Development Disorder • Bariatric surgery • Chiropractic care • Cochlear implants without preauthorization • Complications of a non-covered service • Cosmetic surgery and reconstructive and corrective services, except in limited circumstances	• Dental care (adult/child), except in limited circumstances • Dental check-up • Experimental and/or investigational services • Glasses • Habilitation services • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility (select services) greater than $1,500 per year and $5,000 per lifetime. • Infertility treatment	• Long-term care • Organ transplants if not preauthorized • Orthotic and other corrective appliances for the foot • Services for which a third-party is or may be responsible • Services related to certain illegal activities • Services that are not medically necessary • Temporomandibular Joint (TMJ) services greater than $2,000 lifetime

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.)		
• Non-emergency care when traveling outside the U.S. • Private Duty Nursing, requires preauthorization with limitations	• Routine eye care (adult) • Routine foot care	• Weight loss programs as part of a program approved by SelectHealth

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, or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or 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. 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, kwiijigo 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 $5,220**
- **Patient pays $2,320**

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	$1,000
Co-pays	$20
Co-insurance	$1,150
Limits or exclusions	$150
Total	**$2,320**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $3,600**
- **Patient pays $1,800**

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	$1,000
Co-pays	$510
Co-insurance	$210
Limits or exclusions	$80
Total	**$1,800**

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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Is there an out–of–pocket limit on my expenses?	Yes. **$3,000** person/**$6,000** family participating and **$6,000** person/**$12,000** family non-participating.	The **out-of-pocket limit** 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 out–of–pocket limit?	Premiums, balance-billed charges, infertility services, 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 **out-of-pocket limit**.
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- 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
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	Specialist visit (SCP)	$40/visit	40% co-insurance	Certain limitations apply to allergy testing, treatment and serum. A different benefit may apply for major office surgery over $350. Deductible does not apply to participating services.
	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 to participating services.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% co-insurance	Deductible does not apply to participating services.
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	----------None----------

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
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If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **selecthealth.org**	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. Pharmacy deductible waived for tier 1.
	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 for medical, 20% co-insurance for pharmacy	40% co-insurance for medical, 20% co-insurance for pharmacy	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	----------None----------
	Physician/surgeon fees	20% co-insurance	40% co-insurance	----------None----------
If you need immediate medical attention	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	40% co-insurance	Applies to urgent care facilities only. Deductible does not apply to participating services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	Mental health is not covered.
	Mental/Behavioral health inpatient services	Not covered	Not covered	
	Substance use disorder outpatient services	Not covered	Not covered	
	Substance use disorder inpatient services	Not covered	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	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Rehabilitation services	$40/visit for outpatient, 20% co-insurance for inpatient	40% co-insurance	Up to 20 visits 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	Not covered	Not covered	Habilitation is not covered.
	Skilled nursing care	20% co-insurance	40% co-insurance	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	40% co-insurance	For certain DME, benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Hospice service	20% co-insurance	40% co-insurance	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	40% co-insurance	Deductible does not apply to participating services.
	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/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • Attention-Deficit/Hyperactivity Disorder/Pervasive Development Disorder • Bariatric surgery • Chiropractic care • Cochlear implants without preauthorization • Complications of a non-covered service • Cosmetic surgery and reconstructive and corrective services, except in limited circumstances	• Dental care (adult/child), except in limited circumstances • Dental check-up • Experimental and/or investigational services • Glasses • Habilitation services • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility (select services) greater than $1,500 per year and $5,000 per lifetime. • Infertility treatment	• Long-term care • Mental health and substance abuse disorders • Organ transplants if not preauthorized • Orthotic and other corrective appliances for the foot • Services for which a third-party is or may be responsible • Services related to certain illegal activities • Services that are not medically necessary • Temporomandibular Joint (TMJ) services greater than $2,000 lifetime

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.)		
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Your Rights to Continue Coverage:

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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, kwiijigo 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.

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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
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Co-pays	$20
Co-insurance	$1,050
Limits or exclusions	$150
Total	**$2,720**

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
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Co-pays	$460
Co-insurance	$180
Limits or exclusions	$80
Total	**$2,220**

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.

selecthealth **BEAR RIVER HEAD START**

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

Coverage Period: 12/01/2015 - 11/30/2016
Coverage for: Single/Family | Plan Type: POS

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.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** person/**$6,000** family participating and **$5,000** person/**$10,000** family non-participating per calendar year. Does not apply to office visits, preventive services or prescription drugs. Copays and co-insurance do not apply towards the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	Yes. **$500** per person for prescription drugs. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,000** person/**$10,000** family participating and **$10,000** person/**$20,000** family non-participating.	The **out-of-pocket limit** 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 out–of–pocket limit?	Premiums, balance-billed charges, infertility services, 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 **out-of-pocket limit**.
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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. To find a participating Select Care Plus℠ 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**.

Questions: Call 800-538-5038 or visit us at selecthealth.org. To review your certificate of coverage go to selecthealth.org/materials.
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 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 provider's office or clinic	Primary care visit to treat an injury or illness (PCP)	$30/visit	40% co-insurance	A different benefit may apply for major office surgery over $350. Deductible does not apply to participating services.
	Specialist visit (SCP)	$40/visit	40% co-insurance	Certain limitations apply to allergy testing, treatment and serum. A different benefit may apply for major office surgery over $350. Deductible does not apply to participating services.
	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 to participating services.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% co-insurance	Deductible does not apply to participating services.
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	----------None----------

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Participating	Non-Participating	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **selecthealth.org**	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. Pharmacy deductible waived for tier 1.
	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 for medical, 20% co-insurance for pharmacy	40% co-insurance for medical, 20% co-insurance for pharmacy	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	----------None----------
	Physician/surgeon fees	20% co-insurance	40% co-insurance	----------None----------
If you need immediate medical attention	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	$50/visit	40% co-insurance	Applies to urgent care facilities only. Deductible does not apply to participating services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	Mental health is not covered.
	Mental/Behavioral health inpatient services	Not covered	Not covered	
	Substance use disorder outpatient services	Not covered	Not covered	
	Substance use disorder inpatient services	Not covered	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	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Rehabilitation services	$40/visit for outpatient, 20% co-insurance for inpatient	40% co-insurance	Up to 20 visits 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	Not covered	Not covered	Habilitation is not covered.
	Skilled nursing care	20% co-insurance	40% co-insurance	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	40% co-insurance	For certain DME, benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Hospice service	20% co-insurance	40% co-insurance	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	40% co-insurance	Deductible does not apply to participating services.
	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/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • Attention-Deficit/Hyperactivity Disorder/Pervasive Development Disorder • Bariatric surgery • Chiropractic care • Cochlear implants without preauthorization • Complications of a non-covered service • Cosmetic surgery and reconstructive and corrective services, except in limited circumstances	• Dental care (adult/child), except in limited circumstances • Dental check-up • Experimental and/or investigational services • Glasses • Habilitation services • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility (select services) greater than $1,500 per year and $5,000 per lifetime. • Infertility treatment	• Long-term care • Mental health and substance abuse disorders • Organ transplants if not preauthorized • Orthotic and other corrective appliances for the foot • Services for which a third-party is or may be responsible • Services related to certain illegal activities • Services that are not medically necessary • Temporomandibular Joint (TMJ) services greater than $2,000 lifetime

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.)		
• Non-emergency care when traveling outside the U.S. • Private Duty Nursing, requires preauthorization with limitations	• Routine eye care (adult) • Routine foot care	• Weight loss programs as part of a program approved by SelectHealth

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, or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or 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. 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, kwiijigo 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 $3,620**
- **Patient pays $3,920**

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	$3,000
Co-pays	$20
Co-insurance	$750
Limits or exclusions	$150
Total	**$3,920**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $1,910**
- **Patient pays $3,490**

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	$3,000
Co-pays	$290
Co-insurance	$120
Limits or exclusions	$80
Total	**$3,490**

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?

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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.

selecthealth **BEAR RIVER HEAD START**

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

Coverage Period: 12/01/2015 - 11/30/2016
Coverage for: Single/Family | Plan Type: POS

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.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** person/**$2,000** family participating and **$2,000** person/**$4,000** family non-participating per calendar year. Does not apply to office visits, preventive services or prescription drugs. Copays and co-insurance do not apply towards the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	Yes. **$200** per person for prescription drugs. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,000** person/**$6,000** family participating and **$6,000** person/**$12,000** family non-participating.	The **out-of-pocket limit** 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 out–of–pocket limit?	Premiums, balance-billed charges, infertility services, 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 **out-of-pocket limit**.
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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. To find a participating Select Med Plus℠ 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**.

Questions: Call 800-538-5038 or visit us at selecthealth.org. To review your certificate of coverage go to selecthealth.org/materials.
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 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 provider's office or clinic	Primary care visit to treat an injury or illness (PCP)	$25/visit	40% co-insurance	A different benefit may apply for major office surgery over $350. Deductible does not apply to participating services.
	Specialist visit (SCP)	$40/visit	40% co-insurance	Certain limitations apply to allergy testing, treatment and serum. A different benefit may apply for major office surgery over $350. Deductible does not apply to participating services.
	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 to participating services.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% co-insurance	Deductible does not apply to participating services.
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	----------None----------

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Participating	Non-Participating	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **selecthealth.org**	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. Pharmacy deductible waived for tier 1.
	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 for medical, 20% co-insurance for pharmacy	40% co-insurance for medical, 20% co-insurance for pharmacy	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	----------None----------
	Physician/surgeon fees	20% co-insurance	40% co-insurance	----------None----------
If you need immediate medical attention	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	40% co-insurance	Applies to urgent care facilities only. Deductible does not apply to participating services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 for office visits, 20% co-insurance for outpatient	40% co-insurance for office visits, 40% co-insurance for outpatient	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services. Additional limitations and exclusions apply. Deductible does not apply to participating office visits and outpatient services.
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	
	Substance use disorder outpatient services	$25 for office visits, 20% co-insurance for outpatient	40% co-insurance for office visits, 40% co-insurance for outpatient	
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	

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	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Rehabilitation services	$40/visit for outpatient, 20% co-insurance for inpatient	40% co-insurance	Up to 20 visits 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	Not covered	Not covered	Habilitation is not covered.
	Skilled nursing care	20% co-insurance	40% co-insurance	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	40% co-insurance	For certain DME, benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Hospice service	20% co-insurance	40% co-insurance	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	40% co-insurance	Deductible does not apply to participating services.
	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/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • Attention-Deficit/Hyperactivity Disorder/Pervasive Development Disorder • Bariatric surgery • Chiropractic care • Cochlear implants without preauthorization • Complications of a non-covered service • Cosmetic surgery and reconstructive and corrective services, except in limited circumstances	• Dental care (adult/child), except in limited circumstances • Dental check-up • Experimental and/or investigational services • Glasses • Habilitation services • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility (select services) greater than $1,500 per year and $5,000 per lifetime. • Infertility treatment	• Long-term care • Organ transplants if not preauthorized • Orthotic and other corrective appliances for the foot • Services for which a third-party is or may be responsible • Services related to certain illegal activities • Services that are not medically necessary • Temporomandibular Joint (TMJ) services greater than $2,000 lifetime

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.)		
• Non-emergency care when traveling outside the U.S. • Private Duty Nursing, requires preauthorization with limitations	• Routine eye care (adult) • Routine foot care	• Weight loss programs as part of a program approved by SelectHealth

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, or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or 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. 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, kwiijigo 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 $5,220**
- **Patient pays $2,320**

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	$1,000
Co-pays	$20
Co-insurance	$1,150
Limits or exclusions	$150
Total	**$2,320**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $3,600**
- **Patient pays $1,800**

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	$1,000
Co-pays	$510
Co-insurance	$210
Limits or exclusions	$80
Total	**$1,800**

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.

selecthealth **BEAR RIVER HEAD START**

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

Coverage Period: 12/01/2015 - 11/30/2016
Coverage for: Single/Family | Plan Type: POS

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.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** person/**$3,000** family participating and **$3,000** person/**$6,000** family non-participating per calendar year. Does not apply to office visits, preventive services or prescription drugs. Copays and co-insurance do not apply towards the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	Yes. **$200** per person for prescription drugs. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,000** person/**$6,000** family participating and **$6,000** person/**$12,000** family non-participating.	The **out-of-pocket limit** 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 out–of–pocket limit?	Premiums, balance-billed charges, infertility services, 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 **out-of-pocket limit**.
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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. To find a participating Select Med Plus℠ 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**.

Questions: Call 800-538-5038 or visit us at selecthealth.org. To review your certificate of coverage go to selecthealth.org/materials.
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 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 provider's office or clinic	Primary care visit to treat an injury or illness (PCP)	$25/visit	40% co-insurance	A different benefit may apply for major office surgery over $350. Deductible does not apply to participating services.
	Specialist visit (SCP)	$40/visit	40% co-insurance	Certain limitations apply to allergy testing, treatment and serum. A different benefit may apply for major office surgery over $350. Deductible does not apply to participating services.
	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 to participating services.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% co-insurance	Deductible does not apply to participating services.
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	----------None----------

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Participating	Non-Participating	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **selecthealth.org**	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. Pharmacy deductible waived for tier 1.
	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 for medical, 20% co-insurance for pharmacy	40% co-insurance for medical, 20% co-insurance for pharmacy	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	----------None----------
	Physician/surgeon fees	20% co-insurance	40% co-insurance	----------None----------
If you need immediate medical attention	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	40% co-insurance	Applies to urgent care facilities only. Deductible does not apply to participating services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	Mental health is not covered.
	Mental/Behavioral health inpatient services	Not covered	Not covered	
	Substance use disorder outpatient services	Not covered	Not covered	
	Substance use disorder inpatient services	Not covered	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	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Rehabilitation services	$40/visit for outpatient, 20% co-insurance for inpatient	40% co-insurance	Up to 20 visits 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	Not covered	Not covered	Habilitation is not covered.
	Skilled nursing care	20% co-insurance	40% co-insurance	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	40% co-insurance	For certain DME, benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Hospice service	20% co-insurance	40% co-insurance	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	40% co-insurance	Deductible does not apply to participating services.
	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.)		
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Language Access Services:

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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:

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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
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Co-pays	$20
Co-insurance	$1,050
Limits or exclusions	$150
Total	**$2,720**

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
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Co-pays	$460
Co-insurance	$180
Limits or exclusions	$80
Total	**$2,220**

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.

selecthealth **BEAR RIVER HEAD START**

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

Coverage Period: 12/01/2015 - 11/30/2016
Coverage for: Single/Family | Plan Type: POS

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.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** person/**$6,000** family participating and **$6,000** person/**$12,000** family non-participating per calendar year. Does not apply to office visits, preventive services or prescription drugs. Copays and co-insurance do not apply towards the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	Yes. **$500** per person for prescription drugs. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,000** person/**$10,000** family participating and **$10,000** person/**$20,000** family non-participating.	The **out-of-pocket limit** 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 out–of–pocket limit?	Premiums, balance-billed charges, infertility services, 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 **out-of-pocket limit**.
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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. To find a participating Select Med Plus℠ 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**.

Questions: Call 800-538-5038 or visit us at selecthealth.org. To review your certificate of coverage go to selecthealth.org/materials.
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 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 provider's office or clinic	Primary care visit to treat an injury or illness (PCP)	$30/visit	40% co-insurance	A different benefit may apply for major office surgery over $350. Deductible does not apply to participating services.
	Specialist visit (SCP)	$40/visit	40% co-insurance	Certain limitations apply to allergy testing, treatment and serum. A different benefit may apply for major office surgery over $350. Deductible does not apply to participating services.
	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 to participating services.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% co-insurance	Deductible does not apply to participating services.
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	----------None----------

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Participating	Non-Participating	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **selecthealth.org**	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. Pharmacy deductible waived for tier 1.
	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 for medical, 20% co-insurance for pharmacy	40% co-insurance for medical, 20% co-insurance for pharmacy	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	----------None----------
	Physician/surgeon fees	20% co-insurance	40% co-insurance	----------None----------
If you need immediate medical attention	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	$50/visit	40% co-insurance	Applies to urgent care facilities only. Deductible does not apply to participating services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	Mental health is not covered.
	Mental/Behavioral health inpatient services	Not covered	Not covered	
	Substance use disorder outpatient services	Not covered	Not covered	
	Substance use disorder inpatient services	Not covered	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	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Rehabilitation services	$40/visit for outpatient, 20% co-insurance for inpatient	40% co-insurance	Up to 20 visits 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	Not covered	Not covered	Habilitation is not covered.
	Skilled nursing care	20% co-insurance	40% co-insurance	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	40% co-insurance	For certain DME, benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Hospice service	20% co-insurance	40% co-insurance	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	40% co-insurance	Deductible does not apply to participating services.
	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/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • Attention-Deficit/Hyperactivity Disorder/Pervasive Development Disorder • Bariatric surgery • Chiropractic care • Cochlear implants without preauthorization • Complications of a non-covered service • Cosmetic surgery and reconstructive and corrective services, except in limited circumstances	• Dental care (adult/child), except in limited circumstances • Dental check-up • Experimental and/or investigational services • Glasses • Habilitation services • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility (select services) greater than $1,500 per year and $5,000 per lifetime. • Infertility treatment	• Long-term care • Mental health and substance abuse disorders • Organ transplants if not preauthorized • Orthotic and other corrective appliances for the foot • Services for which a third-party is or may be responsible • Services related to certain illegal activities • Services that are not medically necessary • Temporomandibular Joint (TMJ) services greater than $2,000 lifetime

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.)		
• Non-emergency care when traveling outside the U.S. • Private Duty Nursing, requires preauthorization with limitations	• Routine eye care (adult) • Routine foot care	• Weight loss programs as part of a program approved by SelectHealth

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, or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or 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. 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, kwiijigo 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 $3,620**
- **Patient pays $3,920**

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	$3,000
Co-pays	$20
Co-insurance	$750
Limits or exclusions	$150
Total	**$3,920**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $1,910**
- **Patient pays $3,490**

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	$3,000
Co-pays	$290
Co-insurance	$120
Limits or exclusions	$80
Total	**$3,490**

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.