Select Value HealthSave Silver 3250 (HSA Qualified)

Coverage Period: 01/01/2019 - 12/31/2019

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

Coverage for: Single/Family | Plan Type: HDHP HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit selecthealth.org or call 800-538-5038. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other **underlined** terms see the Glossary. You can view the Glossary at selecthealth.org/sbc or call 800-538-5038 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** single/**$4,000** family participating per calendar year.	Generally, you must pay all the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the policy, the overall family **deductible** must be met before the **plan** begins to pay.
Are there services covered before you meet your deductible?	Yes. **Preventive** care is covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deductible**. See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Per calendar year. Single: **$5,000** participating. Family (two or more): **$5,000** person/**$10,000** family participating.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out–of–pocket limit?	**Premiums**, **balance-billed** charges, **preventive services**, healthcare this **plan** doesn't cover, and penalties for failure to obtain **preauthorization** for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. To find a participating SelectHealth Value® **provider** visit **selecthealth.org/findadoctor** or call Member Services at 800-538-5038.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a provider for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/contracts?I40A1304.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness (PCP)	$25/visit	Not covered	----------None----------
	Specialist visit (SCP)	$40/visit	Not covered	Certain limitations apply to allergy testing, treatment and serum.
	Preventive care / **screening** / immunization	No charge	Not covered	Frequency limitations apply. You may have to pay for services that aren't **preventive**. Ask your **provider** if the services needed are **preventive**. Then check what your **plan** will pay for. **Deductible** does not apply.
If you have a test	**Diagnostic test** (x-ray, blood work)	No charge	Not covered	----------None----------
	Imaging (CT/PET scans, MRIs)	20% **co-insurance**	Not covered	----------None----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at selecthealth.org/prescriptions/default.aspx?st=ut&plan=core	Tier 1	$15/prescription	$15/prescription	Certain limitations apply. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services with nonparticipating **providers**.
	Tier 2	$25/prescription	$25/prescription	
	Tier 3	25% **co-insurance**	25% **co-insurance**	
	Tier 4	50% **co-insurance**	50% **co-insurance**	
	Tier 5	30% **co-insurance**	30% **co-insurance**	
	Specialty drugs	30% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services with nonparticipating **providers**.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services with nonparticipating **providers**.
	Physician/surgeon fees	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services with nonparticipating **providers**.
If you need immediate medical attention	**Emergency room services**	$500/visit	$500/visit	**Emergency room services** apply to participating benefits.
	Emergency medical transportation	20% **co-insurance**	20% **co-insurance**	Emergencies only. **Emergency medical transportation** applies to participating benefits.
	Urgent care	$40/visit	Not covered	Applies to **urgent care** facilities only.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services with nonparticipating **providers**.
	Physician/surgeon fee	20% **co-insurance**	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25/visit for office visits, 20% **co-insurance** for outpatient	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services with nonparticipating **providers**. Additional limitations and exclusions apply.
	Inpatient services	20% **co-insurance**	Not covered	
If you are pregnant	Office visits	$25/visit	Not covered	----------None----------
	Childbirth/delivery professional services	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services with nonparticipating **providers**. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply.
	Childbirth/delivery facility services	20% **co-insurance**	Not covered	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	**Home health care**	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services with nonparticipating **providers**.
	Rehabilitation services	$40/visit for outpatient, 20% **co-insurance** for inpatient	Not covered	Up to 20 visits per year for outpatient physical, speech, and occupational therapies combined. Up to 40 days per 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 with nonparticipating **providers**.
	Habilitation services	$40/visit	Not covered	Up to 20 visits per year for outpatient physical, speech, and occupational therapies combined. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services with nonparticipating **providers**.
	Skilled nursing care	20% **co-insurance**	Not covered	Up to 60 days per calendar year. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services with nonparticipating **providers**.
	Durable medical equipment (DME)	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services with nonparticipating **providers**. A different benefit may apply to prosthetic devices.
	Hospice service	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services with nonparticipating **providers**.
If your child needs dental or eye care	Children's eye exam	$40/visit	Not covered	Covered through age 18.
	Children's glasses	20% **co-insurance**	Not covered	Covered through age 18. Corrective lenses or contacts, one set per year.
	Children's dental check-up	$40/visit	Not covered	Covered through age 18. Two oral examinations and cleanings per calendar year.

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/contracts?I40A1304.

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 • Bariatric surgery • Chiropractic Care • Cochlear implants without **preauthorization** • Cosmetic, reconstructive or corrective services, except in limited circumstances • Dental care (adult/child), except in limited circumstances • Dental check-up (Adult)	• Experimental and/or investigational services • Eyeglass frames • 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 • Non-emergency care when traveling outside the U.S. • Organ transplants and donor fees without **preauthorization**	• 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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.		
• Private Duty Nursing, requires **preauthorization** with limitations • Routine eye care (Adult)	• Routine foot care, covered in limited circumstances • Weight loss programs as part of a program approved by SelectHealth	

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/contracts?I40A1304.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Utah Insurance Department, Office of Consumer Assistance, Suite 3110, State Office Building, Salt Lake City, Utah 84114. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance **Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your plan documents also provide complete information to submit a claim, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform or 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.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

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

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/contracts?I40A1304.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$2,000**
- **Specialist** **$40**
- **Hospital (facility)** **20%**
- **Other** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$110
Coinsurance	$2,304
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,474**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,000**
- **Specialist** **$40**
- **Hospital (facility)** **20%**
- **Other** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$745
Coinsurance	$1,241
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$4,041**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$2,000**
- **Specialist** **$40**
- **Hospital (facility)** **20%**
- **Other** **20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$916
Copayments	$1,780
Coinsurance	$172
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,868**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination Notice

SelectHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free aid and services to people with disabilities to help them communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). We also provide free language services to people whose primary language is not English, such as qualified interpreters and member materials written in other languages.

If you need these services, please call SelectHealth Member Services at 800-538-5038 or SelectHealth Advantage Member Service at 855-442-9900. Any member or other person who believes he/she may have been subject to discrimination may file a complaint or grievance by calling the SelectHealth 504/Civil Rights Coordinator at 844-208-9012 or the Compliance Hotline at 800-442-4845 (TTY Users: 711). You may also call the Office for Civil Rights at 1-800-368-1019 (TTY Users: 800-537-7697).

Language Access Services

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth: **800-538-5038.**

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 SelectHealth: **800-538-5038**. 。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth: **800-538-5038**.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth: **800-538-5038**. 번으로 전화해 주십시오.

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę'ę'', t'áá jiik'eh, éí ná hóló', kojį' hódíílnih SelectHealth: **800-538-5038**.

Nepali

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । SelectHealth: **800-538-5038** मा फोन गर्नुहोस्।

Tongan

FAKATOKANGA'I: Kapau 'oku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta'etotongi, pea te ke lava 'o ma'u ia. Telefoni ki he SelectHealth: **800-538-5038**.

Serb-Croatian

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите SelectHealth: **800-538-5038**.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth: **800-538-5038**.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth: **800-538-5038**.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth: **800-538-5038**

Arabic

ةظوحلم: اذإ تنك تحدثت ثيبرعلا ،فإ تامدخ ةدعاسملا ناجملاب .لصتا ةكرشب كل رفاوتت ةيوغللا SelectHealth: **800-538-5038**

Mon-khmer, Cambodian

សម្គាល់៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់ អ្នក។ សូមទូរស័ព្ទមក SelectHealth: **800-538-5038** ។

French

ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth: **800-538-5038**.

Japanese

注意事項：日本語を話される場合、無料の言語 支援をご利用いただけます。SelectHealth: **800-538-5038**. まで、お電話にてご連絡ください。

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