selecthealth **Select Value Silver 2100**

**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: 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?** | **$1,500** person/**$3,000** 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 **plan**, each family member must meet their own individual **deductible** until the total amount of deductible expenses paid by all family members meets the overall family **deductible**. |
| **Are there services covered before you meet your deductible?** | Yes. Prescription drugs and **preventive services** are 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?** | 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. |
| **What is the out-of-pocket limit for this plan?** | **$5,200** person/**$10,400** family participating per calendar year. | 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?I40A1273.

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) | $35/visit | Not covered | ----------None---------- |
| | **Specialist** visit (SCP) | $60/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) | 30% **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**. Pharmacy **deductible** waived for tiers 1 and 2. |
| | Tier 2 | $25/prescription | $25/prescription | |
| | Tier 3 | 25% **co-insurance** | 25% **co-insurance** | |
| | Tier 4 | 50% **co-insurance** | 50% **co-insurance** | |
| | Tier 5 | 40% **co-insurance** | 40% **co-insurance** | |
| | **Specialty drugs** | 40% **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) | 30% **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 | 30% **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** | 30% **co-insurance** | 30% **co-insurance** | Emergencies only. **Emergency medical transportation** applies to participating benefits. |
| | **Urgent care** | $60/visit | Not covered | Applies to **urgent care** facilities only. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% **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 | 30% **co-insurance** | Not covered | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $35/visit for office visits, 30% **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 | 30% **co-insurance** | Not covered | |
| **If you are pregnant** | Office visits | $35/visit | Not covered | ----------None---------- |
| | Childbirth/delivery professional services | 30% **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 | 30% **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** | 30% **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** | $60/visit for outpatient, 30% **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** | $60/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** | 30% **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)** | 30% **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** | 30% **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 | $60/visit | Not covered | Covered through age 18. |
| | Children's glasses | 30% **co-insurance** | Not covered | Covered through age 18. Corrective lenses or contacts, one set per year. |
| | Children's dental check-up | $60/visit | Not covered | Covered through age 18. Two oral examinations and cleanings per calendar year. **Deductible** does not apply. |

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/contracts?I40A1273.

## 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<br>• Acupuncture<br>• Administrative services/charges<br>• Bariatric surgery<br>• Chiropractic Care<br>• Cochlear implants without **preauthorization**<br>• Cosmetic, reconstructive or corrective services, except in limited circumstances<br>• Dental care (adult/child), except in limited circumstances<br>• Dental check-up (Adult) | • Experimental and/or investigational services<br>• Eyeglass frames<br>• Hearing aids<br>• Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever<br>• Infertility (select services) greater than $1,500 per year and $5,000 per lifetime<br>• Infertility treatment<br>• Long-term care<br>• Non-emergency care when traveling outside the U.S.<br>• Organ transplants and donor fees without **preauthorization** | • Orthotic and other corrective appliances for the foot<br>• Services for which a third-party is or may be responsible<br>• Services related to certain illegal activities<br>• Services that are not **medically necessary**<br>• 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<br>• Routine eye care (Adult) | • Routine foot care, covered in limited circumstances<br>• 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?I40A1273.

## 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?I40A1273.

## 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** **$1,500**
- **Specialist** **$60**
- **Hospital (facility)** **30%**
- **Other** **30%**

**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 | $1,500 |
| Copayments | $130 |
| Coinsurance | $3,455 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$5,145** |

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

- **The plan's overall deductible** **$1,500**
- **Specialist** **$60**
- **Hospital (facility)** **30%**
- **Other** **30%**

**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 | $865 |
| Coinsurance | $1,414 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$4,334** |

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

- **The plan's overall deductible** **$1,500**
- **Specialist** **$60**
- **Hospital (facility)** **30%**
- **Other** **30%**

**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 | $729 |
| Copayments | $1,920 |
| Coinsurance | $258 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,907** |

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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