Group Health Plan Notices

Annual Required Legal Notices and Disclosures for Plan Participants

The following notices provide important information about your employer provided group health plan. Please read the notices carefully and keep a copy for your records. If you have any questions regarding these notices, please contact Human Resources or the plan administrator at kortiz@tooeleschools.org or (435) 833-1900 ext 1103.

Medicare Part D Notice

Important Notice About Your Creditable Prescription Drug Coverage and Medicare

If you or any of your eligible dependents are eligible for Medicare, or will soon become eligible for Medicare, please read this notice. If not, you can disregard this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area. Your medical benefits brochure contains a description of your current prescription drug benefits. If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

This information is only a summary and does not supersede the carrier provided contracts and general provisions found in your plan documents should there be a conflict.

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage…

Contact Human Resources for further information.

NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact the plan administrator.

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Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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HIPAA Non-Discrimination Requirements

The Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating with regard to eligibility, premiums, or contributions on the basis of specified health status-related factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability.

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Notice of HIPAA Special Enrollment Rights

A federal law called HIPAA requires that we notify you of your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. You have the right to request special enrollment (outside of the plan's annual enrollment period) for yourself and your eligible dependents under the following circumstances.

Special Enrollment Provisions

Loss of Other Coverage (Except Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Eligibility Under Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

Other mid-year election changes may be permitted under your plan (refer to "Permitted Midyear Election Changes" section below).

To request special enrollment or obtain more information, contact Human Resources.

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Permitted Midyear Election Changes

Under Internal Revenue Service (IRS) regulations, in order to be eligible to take premium contributions using pre-tax dollars, elections generally must be irrevocable for the entire plan year (with the exception of HSA benefit elections, for which prospective election changes must be allowed at least monthly and upon loss of HSA eligibility). As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will generally remain in place until the next open enrollment period, unless you have an approved election change event and certain other conditions are met as outlined in IRS Code Section 125. See your Section 125 premium conversion plan summary plan description (SPD) for further details and a complete listing of permitted change in election events.

Examples of permitted change in election events include:

- Change in legal marital status (e.g., marriage, divorce, annulment, or legal separation)
- Change in number of dependents (e.g., birth, adoption, or death)
- Change in your employment status or your spouse's or covered child's change in employment (e.g., reduction in hours affecting eligibility or change in employment)
- Your child satisfies or ceases to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the plan under which you receive coverage
- You and/or your spouse or covered child has a change of residence
- Your spouse or covered child makes an election change during an open enrollment period under his or her employer's cafeteria plan, but only if the change under this Plan is consistent with and on account of your spouse's or covered child's change.
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment

These are just some examples of permitted mid-year change in election events. Consult with Human Resources for other circumstances that may be permissible mid-year change in election events.

You must notify Human Resources within 30 days of the above change in status, with the exception of the loss of eligibility or enrollment in Medicaid or state health insurance programs - which requires notice within 60 days.

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HIPAA Notice of Privacy Practices

Notice of Health Information Privacy Practices

This Notice of Privacy Practices describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice describes the legal obligations of your group health plan and your legal rights regarding certain health information, called protected health information (PHI), held by the group health plan under the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and the corresponding regulations (collectively referred to as "HIPAA"). The group health plan is sponsored by your employer. If you have any questions about this notice or about the group health plan's privacy practices, or wish to exercise any of your privacy rights, please contact human resources.

How the Health Plan Uses and Discloses Protected Health Information

Under HIPAA, the plan may use or disclose protected health information (PHI) under certain circumstances without your permission, provided that the legal requirements applicable to the use or disclosure are followed. The following categories describe the different ways that we may use and disclose your PHI. Not every use or disclosure in a category will be listed. However, all the ways permitted to use and disclose information will fall within one of the categories. Most of the time the plan will use, disclose, and request only the minimum information necessary for these purposes.

For treatment. The plan may use or disclose PHI to facilitate medical treatment or services by health providers. The plan may disclose health information about you to health care providers, including doctors, nurses, technicians, or hospital personnel who need the information to take care of you. For example, the plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription conflicts with your current prescriptions.

For payment. The plan may use or disclose PHI to make payments to health care providers who are taking care of you. The plan may also use and disclose PHI to determine your eligibility for plan benefits, to evaluate the plan's benefit responsibility, and to coordinate plan coverage with other coverage you may have. For example, the plan may share information with health care providers to determine whether the plan will cover a particular treatment. The plan may also share your PHI with another organization to assist with financial recoveries from responsible third parties

For health care operations. The plan may use and disclose PHI to run the plan. For example, the plan may use PHI in connection with quality assessment and improvement activities; care coordination and case management; underwriting, premium rating, and other activities relating to plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general plan administrative activities. However, the plan will not use genetic information for underwriting purposes.

To Business Associates. The plan may contract with third parties, known as "Business Associates," to perform various functions or provide various services on behalf of the plan. To perform these functions or to provide these services, Business Associates may receive, create, maintain, transmit, use, and disclose protected health

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information, but only after they agree in writing to safeguard PHI and respect your HIPAA rights. For example, the plan may disclose PHI to a third-party administrator to process claims for plan benefits.

As required by law. The plan will disclose PHI when required to do so by federal, state, or local law.

To prevent a serious threat to health or safety. The plan may use and disclose PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

To the employer. The plan may disclose PHI to certain employees of the employer who are involved with plan administration. These employees are permitted to use or disclose PHI only to perform plan administration functions or as otherwise permitted or required by HIPAA, unless you have authorized further disclosures. PHI cannot be used for employment purposes without your specific authorization.

Workers' compensation. The plan may disclose PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public health. The plan may disclose PHI for public health activities, including, for example, to prevent or control disease, injury, or disability; or to report child abuse or neglect.

Health oversight. The plan may disclose PHI to a health oversight agency for activities authorized by law, including, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and disputes. The plan may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Law enforcement. The plan may disclose PHI if asked to do so by a law-enforcement official in certain limited circumstances.

Family members. The plan may disclose PHI to a family member or close personal friend who is involved in your care or payment for your care or for notification purposes. Generally, you will have an opportunity to object to these disclosures. With only limited exceptions, all mail regarding the plan will be sent to the employee unless we have agreed otherwise. This includes mail relating to participation of the employee's spouse and other family members in the plan, such as availability of plan benefits and information on the processing of any plan benefits (including explanations of benefits (EOBs)).

Coroners, medical examiners, and funeral directors. The plan may disclose PHI to a coroner, medical examiner, or funeral director, as necessary for them to carry out their duties.

National security and intelligence activities. The plan may disclose PHI to authorized federal officials for national security activities authorized by law.

Military. The plan may disclose PHI as required by military and veterans authorities if you are or were a member of the uniformed services.

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Research. In very limited situations, the plan may disclose protected health information to researchers; however, usually we will need to get your authorization.

Compliance with HIPAA. The plan is required to disclose PHI to the United States Department of Health and Human Services when requested to determine compliance with HIPAA.

Substance Use Disorder (SUD) Treatment Information. If the plan receives or maintains any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, the plan may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this notice. If the plan receives or maintains your Part 2 Program record through specific consent you provide to the plan or another third party, the plan will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to the plan.

In no event will the plan use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

Authorizations. Other uses or disclosures of PHI not described above will be made only with your written authorization. For example, the plan generally needs your authorization to disclose psychiatric notes about you; to use or disclose PHI for marketing; or to sell PHI. You may revoke your authorizations at any time, so long as the revocation is in writing. However, the revocation will not be effective for any uses or disclosures made in reliance upon the authorization.

Your Rights

You have the rights described below with respect to PHI about you, subject to certain conditions and exceptions.

Get a copy of health and claims records. You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records. You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

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Get a list of those with whom we've shared information. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting Human Resources. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: (1) Share information with your family, close friends, or others involved in payment for your care. (2) Share information in a disaster relief situation. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission: (1) Marketing purposes. (2) Sale of your information.

The Plan's Responsibilities

The plan is required to:

- Maintain the privacy and security of your PHI.
- Let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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More Information

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact Human Resources and the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer, or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.
- The plan reserves the right to change the terms of this notice and to make new provisions effective for all PHI that the plan maintains, including PHI created or received prior to any revision. If significant changes are made, the plan will furnish you with a revised copy.

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Important Information on How Health Care Reform Impacts Your Plan

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office.

For plans and issuers that require or allow for the designation of a primary care provider for a child:

- For children, you may designate a pediatrician as the primary care provider. For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:
- You do not need prior authorization from your insurance provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Human Resources office.

Grandfathered Plans

If your group health plan is grandfathered, then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources.

Prohibition on Excess Waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan.

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Prohibition on Preexisting Condition Exclusions

Effective for Plan Years on or after January 1, 2014, group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A preexisting condition includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information. Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1] [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace? You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

[*NOTE: The following two paragraphs are part of the current model Exchange Notice provided by the DOL and therefore is included. However, because the COVID public health emergency has ended, and because we are past these temporary COVID-specific special enrollment periods, these two paragraphs are no longer relevant*.]

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage**. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage? If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact the plan administrator. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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Your Employee Rights Under the Family and Medical Leave Act (FMLA)

The FMLA only applies to employers that meet certain criteria. A covered employer is a:

- ***Private-sector employer with 50 or more employees in 20 or more workweeks in the current or preceding calendar year (including a joint employer or successor in interest).***
- ***Public agency (including a local, state, or Federal government agency) regardless of number of employees.***
- ***Public or private elementary or secondary school, regardless of number of employees.***

What is FMLA Leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with job-protected leave for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take up to 12 workweeks of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness may take up to 26 workweeks of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in one block of time. When it is medically necessary or otherwise permitted, you may take FMLA leave intermittently in separate blocks of time, or on a reduced schedule by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is not paid leave, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I Eligible to Take FMLA Leave?

You are an eligible employee if all of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a covered employer if one of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,

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- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management

How Do I Request FMLA Leave?

Generally, to request FMLA leave you must:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You do not have to share a medical diagnosis but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You must also inform your employer if FMLA leave was previously taken or approved for the same reason when requesting additional leave.

Your employer may request certification from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What Does My Employer Need to Do?

If you are eligible for FMLA leave, your employer must:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your employer cannot interfere with your FMLA rights or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your employer must confirm whether you are eligible or not eligible for FMLA leave. If your employer determines that you are eligible, your employer must notify you in writing:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where Can I Find More Information?

Call 1-866-487-9243 or visit dol.gov/fmla to learn more.

This information is only a summary and does not supersede the carrier provided contracts and general provisions found in your plan documents should there be a conflict.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. Visit www.dol.gov/agencies/whd/contact/complaints to learn about the WHD complaint process.

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Your Rights under the Uniformed Services Employment & Reemployment Rights Act (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service;

then an employer may not deny you

- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment.

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

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Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets*. An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm*.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm*. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

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Medicare and Health Savings Accounts (HSAs)

If you are approaching Medicare eligibility and you currently contribute to a Health Savings Account (HSA) that is integrated with a High Deduction Health Plan (HDHP), it is important to understand how HSA eligibility rules and Medicare enrollment interact.

An individual is not eligible to make HSA contributions (nor eligible to have employer contributions made to their HSA) if the individual has other coverage including being enrolled in Medicare. An individual who is enrolled in Medicare is not eligible for continued HSA contributions, however, funds that existed in the HSA prior to Medicare enrollment may continue to be used for ongoing medical expenses.

It is important to be aware that Medicare enrollment based on age or disability cannot be waived by individuals who are receiving Social Security benefits. However, Medicare enrollment may be delayed by delaying the receipt of Social Security benefits. For those that delay applying for Medicare, enrollment is generally retroactive for up to six months (that is, Medicare coverage will begin up to six months prior to the month in which they applied). Because the first month of Medicare enrollment will be retroactive for individuals who delay applying for Medicare, those individuals should use extra care when determining the amount of their HSA contributions to avoid excess contributions and possible adverse tax consequences.

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Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing.

What is "balance billing" (or sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services. If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center. When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

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When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, the federal phone number for information and complaints is: 1-800-985-3059. Also visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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Continuation Coverage Rights Under COBRA

Your employer's group health plan may not be subject to COBRA (and this notice will not apply) if your employer had fewer than 20 employees on a typical business day during the preceding calendar year. If your plan is not subject to COBRA, it may be subject to state continuation rights which are similar to COBRA continuation rights.

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it**. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Continuation Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage. If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage. If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally

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separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[3] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to Human Resources. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

[3] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

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Select Health

Coverage Period: 09/01/2026 - 08/31/2027
Coverage for: Single/Family | Plan Type: HDHP POS

TOOELE COUNTY SCHOOL DISTRICT

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?	**$1,700** single/**$3,400** family in-network and **$2,000** single/**$4,000** family out-of-network per **plan** 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, for in-network **providers**: **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?	**$3,000** single/**$6,000** family in-network and **$4,500** single/**$9,000** family out-of-network.	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**, the overall family **out-of-pocket limit** must be met.
What is not included in the out–of–pocket limit?	**Premiums**, **balance-billed** charges, 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 an in-network SelectHealth Care® **provider** visit **selecthealth.org/find-care** 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/materials.

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)	No charge	40% **co-insurance**	A different benefit may apply for major office surgery.
	Specialist visit (SCP)	No charge	40% **co-insurance**	A different benefit may apply for major office surgery.
	Preventive care / **screening** / immunization	No charge	Not covered	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. Frequency limitations apply.
If you have a test	**Diagnostic test** (x-ray, blood work)	No charge	40% **co-insurance**	----------None----------
	Imaging (CT/PET scans, MRIs)	No charge	40% **co-insurance**	----------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=select**	Standard Tier 1 (generic drugs)	No charge	No charge	Certain limitations apply. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Standard Tier 2 (preferred brand drugs)	No charge	No charge	
	Standard Tier 3 (non-preferred brand drugs)	No charge	No charge	
	Maintenance Tier 1 (generic drugs)	No charge	No charge	
	Maintenance Tier 2 (preferred brand drugs)	No charge	No charge	
	Maintenance Tier 3 (non-preferred brand drugs)	No charge	No charge	
	Specialty drugs	No charge	No charge	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.

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

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)	No charge	40% **co-insurance**	----------None----------
	Physician/surgeon fees	No charge	40% **co-insurance**	----------None----------
If you need immediate medical attention	**Emergency room services**	No charge	No charge	**Emergency room services** apply to in-network benefits.
	Emergency medical transportation	No charge	No charge	Emergencies only. **Emergency medical transportation** applies to in-network benefits.
	Urgent care	No charge	40% **co-insurance**	Applies to **urgent care** facilities only.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	40% **co-insurance**	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Physician/surgeon fee	No charge	40% **co-insurance**	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	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.
	Inpatient services	No charge	40% **co-insurance**	
If you are pregnant	Office visits	No charge	40% **co-insurance**	Cost sharing does not apply to **preventive services**. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply. Maternity care may include test and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	40% **co-insurance**	Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be pre-authorized at the time the **provider** recommends the extended stay.
	Childbirth/delivery facility services	No charge	40% **co-insurance**	

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**	No charge	40% **co-insurance**	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Rehabilitation services	No charge	40% **co-insurance**	Up to 40 days per **plan** 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	No charge	40% **co-insurance**	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Skilled nursing care	No charge	40% **co-insurance**	Up to 60 days per **plan** year. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Durable medical equipment (DME)	No charge	40% **co-insurance**	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Hospice service	No charge	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	Children's eye exam	No charge	40% **co-insurance**	**Preventive** benefits abide by the ACA and are covered at 100%. One routine eye exam covered per calendar year.
	Children's glasses	Not covered	Not covered	Glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortions/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • 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 • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility treatment • Long-term care	• Orthotic and other corrective appliances for the foot • Services that are not **medically necessary** • Temporomandibular Joint (TMJ) services greater than $2,000 lifetime

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery, **preauthorization** required with limitations • Chiropractic care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing, **preauthorization** required with limitations	• Routine eye care (adult) • Routine foot care • Weight loss programs as part of a program approved by Select Health

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Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes **plans**, **health insurance** available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the **premium tax credit**.

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.

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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	$1,700
Specialist	Covered 100%
Hospital (facility)	Covered 100%
Other	Covered 100%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,760**

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

The plan's overall deductible	$1,700
Specialist	Covered 100%
Hospital (facility)	Covered 100%
Other	Covered 100%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

The plan's overall deductible	$1,700
Specialist	Covered 100%
Hospital (facility)	Covered 100%
Other	Covered 100%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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

Fair Treatment Notice

Select Health obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

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 Select Health Member Services at 800-538-5038 or Select Health 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 Select Health 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

English

ATTENTION: If you speak Spanish, free language assistance services are available to you. Call Select Health.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Select Health.

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 Select Health

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Select Health.

Korean

통지: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Select Health. 번호로 전화해 주십시오.

Nepali

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्ननुनुहुन्छ भने तपाईको नि म्ति भाषा सहायता सेवाहरू नि ःशुल्क रूपमा उपलब्ध छ। Select Health मा फोन गर्ननुनुहोस्।

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Select Health.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Select Health.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните Select Health.

French

ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez Select Health.

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。Select Health. まで、お電話にてご連絡ください。

Amharic

ማሳሰቢያ፡ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎቶች ያለክፍያ ለእርስዎ ይገኛሉ። Select Health ን ያናግሩ።

Serb-Croatian

ПАЖЊА: Ако говорите Српски, бесплатне услуге пмоћи за језик, биће вам доступне. Контактирајте Select Health.

Arabic

تامدخ كل رفوتتسف، ببرع ثدحتت تنك اذإ: هيبنت
ب لصتا .أناجم ةيوغلا ةدعاسملا Select Health.

Persian

هجوت: دينكيم تبحص ينک دراو ار نابز هب رگا، تامدخ
اب .تسامش رايتخا رد ناگيار تروصب، ينابز كمک
ديريگب سامت Select Health.

Thai

หมายเหตุ: หากคุณพูด ใส่ภาษา, การบริการภาษาโดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ Select Health

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

Select Health

TOOELE COUNTY SCHOOL DISTRICT

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?	**$1,700** person/**$3,400** family in-network and **$3,400** person/**$6,800** family out-of-network per **plan** 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, for in-network **providers**: **preventive** care, office visits, prescription drugs, and chiropractic 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. **$100** 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?	**$4,000** person/**$8,000** family in-network and **$8,000** person/**$16,000** family out-of-network.	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, 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 an in-network SelectHealth Care® **provider** visit **selecthealth.org/find-care** 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/materials.

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)	$40/visit, **deductible** does not apply	40% **co-insurance**	A different benefit may apply for major office surgery.
	Specialist visit (SCP)	$50/visit, **deductible** does not apply	40% **co-insurance**	A different benefit may apply for major office surgery.
	Preventive care / **screening** / immunization	No charge, **deductible** does not apply	Not covered	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. Frequency limitations apply.
If you have a test	**Diagnostic test** (x-ray, blood work)	No charge, **deductible** does not apply	40% **co-insurance**	----------None----------
	Imaging (CT/PET scans, MRIs)	20% **co-insurance**	40% **co-insurance**	----------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=select**	Standard Tier 1 (generic drugs)	20% **co-insurance**, pharmacy **deductible** does not apply.	20% **co-insurance**, pharmacy **deductible** does not apply.	Certain limitations apply. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Standard Tier 2 (preferred brand drugs)	30% **co-insurance**	30% **co-insurance**	
	Standard Tier 3 (non-preferred brand drugs)	40% **co-insurance**	40% **co-insurance**	
	Maintenance Tier 1 (generic drugs)	$10/prescription, pharmacy **deductible** does not apply.	$10/prescription, pharmacy **deductible** does not apply.	
	Maintenance Tier 2 (preferred brand drugs)	$50/prescription	$50/prescription	
	Maintenance Tier 3 (non-preferred brand drugs)	$135/prescription	$135/prescription	
	Specialty drugs	20% **co-insurance**	20% **co-insurance**	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.

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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**, 10% **co-insurance** for ambulatory surgical center	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 then 20% **co-insurance**	$250/visit then 20% **co-insurance**	**Emergency room services** apply to in-network benefits.
	Emergency medical transportation	20% **co-insurance**	20% **co-insurance**	Emergencies only. **Emergency medical transportation** applies to in-network benefits.
	Urgent care	$50/visit, **deductible** does not apply	40% **co-insurance**	Applies to **urgent care** facilities only.
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 need mental health, behavioral health, or substance abuse services	Outpatient services	$40 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.
	Inpatient services	20% **co-insurance**	40% **co-insurance**	
If you are pregnant	Office visits	$40/visit, **deductible** does not apply	40% **co-insurance**	Cost sharing does not apply to **preventive services**. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply. Maternity care may include test and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% **co-insurance**	40% **co-insurance**	Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be pre-authorized at the time the **provider** recommends the extended stay.
	Childbirth/delivery facility services	20% **co-insurance**	40% **co-insurance**	

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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**	40% **co-insurance**	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Rehabilitation services	$50/visit for outpatient, 20% **co-insurance** for inpatient	40% **co-insurance**	Up to 40 days per **plan** 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	$50/visit	40% **co-insurance**	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Skilled nursing care	20% **co-insurance**	40% **co-insurance**	Up to 60 days per **plan** 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**	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	Children's eye exam	$50/visit, **deductible** does not apply	40% **co-insurance**	**Preventive** benefits abide by the ACA and are covered at 100%. One routine eye exam covered per calendar year.
	Children's glasses	Not covered	Not covered	Glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered.

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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery, **preauthorization** required with limitations • Chiropractic care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing, **preauthorization** required with limitations	• Routine eye care (adult) • Routine foot care • Weight loss programs as part of a program approved by Select Health

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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.

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About these Coverage Examples:

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

The plan's overall deductible	$1,700
Specialist	$50
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,960**

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

The plan's overall deductible	$1,700
Specialist	$50
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

The plan's overall deductible	$1,700
Specialist	$50
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

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

Fair Treatment Notice

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Korean

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Nepali

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Tagalog

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Serb-Croatian

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Arabic

تامدخ كل رفوتتسف، ببرع تدحتت تنك اذإ :هيبنت
اًناجم ةيوغللا ةدعاسملا ب لصتا .Select Health.

Persian

تامدخ، دينكيم تبحص ينک دراو ار نابز هب رگا :هجوت
اب .تسامش رايتخا رد ناگيار تروصب، ينابز كمک
ديريگب سامت Select Health.

Thai

หมายเหตุ: หากคุณพูด ใส่ภาษา, การบริการภาษาโดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ Select Health

Select Health: 1-800-538-5038

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

Select Health

Coverage Period: 09/01/2026 - 08/31/2027
Coverage for: Single/Family | Plan Type: HDHP POS

TOOELE COUNTY SCHOOL DISTRICT

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?	**$3,400** person/**$6,800** family in-network and **$3,750** person/**$7,500** family out-of-network per **plan** 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, for in-network **providers**: **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?	**$4,000** person/**$8,000** family in-network and **$5,500** person/**$11,000** family out-of-network.	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, 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 an in-network SelectHealth Care® **provider** visit **selecthealth.org/find-care** 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**.

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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)	$15/visit	40% **co-insurance**	A different benefit may apply for major office surgery.
	Specialist visit (SCP)	$25/visit	40% **co-insurance**	A different benefit may apply for major office surgery.
	Preventive care / **screening** / immunization	No charge, **deductible** does not apply.	Not covered	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. Frequency limitations apply.
If you have a test	**Diagnostic test** (x-ray, blood work)	No charge	40% **co-insurance**	----------None----------
	Imaging (CT/PET scans, MRIs)	20% **co-insurance**	40% **co-insurance**	----------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=select**	Standard Tier 1 (generic drugs)	$7/prescription	$7/prescription	Certain limitations apply. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Standard Tier 2 (preferred brand drugs)	$21/prescription	$21/prescription	
	Standard Tier 3 (non-preferred brand drugs)	$42/prescription	$42/prescription	
	Maintenance Tier 1 (generic drugs)	$7/prescription	$7/prescription	
	Maintenance Tier 2 (preferred brand drugs)	$42/prescription	$42/prescription	
	Maintenance Tier 3 (non-preferred brand drugs)	$126/prescription	$126/prescription	
	Specialty drugs	$100/prescription	$100/prescription	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.

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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**, 10% **co-insurance** for ambulatory surgical center	40% **co-insurance**	----------None----------
	Physician/surgeon fees	20% **co-insurance**	40% **co-insurance**	----------None----------
If you need immediate medical attention	**Emergency room services**	$75/visit	$75/visit	**Emergency room services** apply to in-network benefits.
	Emergency medical transportation	20% **co-insurance**	20% **co-insurance**	Emergencies only. **Emergency medical transportation** applies to in-network benefits.
	Urgent care	$35/visit	40% **co-insurance**	Applies to **urgent care** facilities only.
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 need mental health, behavioral health, or substance abuse services	Outpatient services	$15 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.
	Inpatient services	20% **co-insurance**	40% **co-insurance**	
If you are pregnant	Office visits	$15/visit	40% **co-insurance**	Cost sharing does not apply to **preventive services**. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply. Maternity care may include test and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% **co-insurance**	40% **co-insurance**	Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be pre-authorized at the time the **provider** recommends the extended stay.
	Childbirth/delivery facility services	20% **co-insurance**	40% **co-insurance**	

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**	40% **co-insurance**	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Rehabilitation services	$25/visit for outpatient, 20% **co-insurance** for inpatient	40% **co-insurance**	Up to 40 days per **plan** 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	$25/visit	40% **co-insurance**	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Skilled nursing care	20% **co-insurance**	40% **co-insurance**	Up to 60 days per **plan** 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**	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	Children's eye exam	$25/visit	40% **co-insurance**	**Preventive** benefits abide by the ACA and are covered at 100%. One routine eye exam covered per calendar year.
	Children's glasses	Not covered	Not covered	Glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortions/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • 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 • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility treatment • Long-term care	• Orthotic and other corrective appliances for the foot • Services that are not **medically necessary** • Temporomandibular Joint (TMJ) services greater than $2,000 lifetime

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery, **preauthorization** required with limitations • Chiropractic care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing, **preauthorization** required with limitations	• Routine eye care (adult) • Routine foot care • Weight loss programs as part of a program approved by Select Health

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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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov; or contact the **Plan**. 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.

To contact Select Health Member Services, please call 800-538-5038 weekdays, TTY users should call 711, or visit us at selecthealth.org.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes **plans**, **health insurance** available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the **premium tax credit**.

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.

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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** **$3,400**
- **Specialist** **$25**
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,400
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,160**

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

- **The plan's overall deductible** **$3,400**
- **Specialist** **$25**
- **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,400
Copayments	$100
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,600**

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

- **The plan's overall deductible** **$3,400**
- **Specialist** **$25**
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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Serb-Croatian

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Arabic

تامدخ كل رفوتتسف، ببرع ثدحتت تنك اذإ: هيبنت
ب لصتا .أناجم ةيوغلا ةدعاسملا Select Health.

Persian

هجوت: دينكيم تبحص ينک دراو ار نابز هب رگا، تامدخ
اب .تسامش رايتخا رد ناگيار تروصب، ينابز كمک
ديريگب سامت Select Health.

Thai

หมายเหตุ: หากคุณพูด ใส่ภาษา, การบริการภาษาโดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ Select Health

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

Select Health

Coverage Period: 09/01/2026 - 08/31/2027
Coverage for: Single/Family | Plan Type: HDHP HMO

TOOELE COUNTY SCHOOL DISTRICT

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,700** single/**$3,400** family per **plan** 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?	**$3,000** single/**$6,000** family.	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**, the overall family **out-of-pocket limit** must be met.
What is not included in the out–of–pocket limit?	**Premiums**, **balance-billed** charges, 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 an in-network SelectHealth Share® **provider** visit **selecthealth.org/find-care** 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/materials.

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)	No charge	Not covered	A different benefit may apply for major office surgery.
	Specialist visit (SCP)	No charge	Not covered	A different benefit may apply for major office surgery.
	Preventive care / **screening** / immunization	No charge, **deductible** does not apply.	Not covered	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. Frequency limitations apply.
If you have a test	**Diagnostic test** (x-ray, blood work)	No charge	Not covered	----------None----------
	Imaging (CT/PET scans, MRIs)	No charge	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=select**	Standard Tier 1 (generic drugs)	No charge	No charge	Certain limitations apply. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Standard Tier 2 (preferred brand drugs)	No charge	No charge	
	Standard Tier 3 (non-preferred brand drugs)	No charge	No charge	
	Maintenance Tier 1 (generic drugs)	No charge	No charge	
	Maintenance Tier 2 (preferred brand drugs)	No charge	No charge	
	Maintenance Tier 3 (non-preferred brand drugs)	No charge	No charge	
	Specialty drugs	No charge	No charge	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.

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

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)	No charge	Not covered	----------None----------
	Physician/surgeon fees	No charge	Not covered	----------None----------
If you need immediate medical attention	**Emergency room services**	No charge	No charge	**Emergency room services** apply to in-network benefits.
	Emergency medical transportation	No charge	No charge	Emergencies only. **Emergency medical transportation** applies to in-network benefits.
	Urgent care	No charge	Not covered	Applies to **urgent care** facilities only.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Physician/surgeon fee	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services. Additional limitations and exclusions apply.
	Inpatient services	No charge	Not covered	
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to **preventive services**. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply. Maternity care may include test and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be pre-authorized at the time the **provider** recommends the extended stay.
	Childbirth/delivery facility services	No charge	Not covered	

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**	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Rehabilitation services	No charge	Not covered	Up to 40 days per **plan** 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	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Skilled nursing care	No charge	Not covered	Up to 60 days per **plan** year. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Durable medical equipment (DME)	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Hospice service	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	**Preventive** benefits abide by the ACA and are covered at 100%. One routine eye exam covered per calendar year.
	Children's glasses	Not covered	Not covered	Glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortions/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • 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 • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S., except for **urgent care** • Orthotic and other corrective appliances for the foot • Services that are not **medically necessary** • Temporomandibular Joint (TMJ) services greater than $2,000 lifetime

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery, **preauthorization** required with limitations • Chiropractic care	• Private-duty nursing, **preauthorization** required with limitations • Routine eye care (adult)	• Routine foot care • Weight loss programs as part of a program approved by Select Health

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

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov; or contact the **Plan**. 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.

To contact Select Health Member Services, please call 800-538-5038 weekdays, TTY users should call 711, or visit us at selecthealth.org.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes **plans**, **health insurance** available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the **premium tax credit**.

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/materials.

Select Health

TOOELE COUNTY SCHOOL DISTRICT

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?	**$1,700** person/**$3,400** family per **plan** year.	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 services covered before you meet your deductible?	Yes. **Preventive** care, office visits, prescription drugs, and chiropractic 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. **$100** 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?	**$4,000** person/**$8,000** family.	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, 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 an in-network SelectHealth Share® **provider** visit **selecthealth.org/find-care** 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/materials.

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)	$40/visit, **deductible** does not apply	Not covered	A different benefit may apply for major office surgery.
	Specialist visit (SCP)	$50/visit, **deductible** does not apply	Not covered	A different benefit may apply for major office surgery.
	Preventive care / **screening** / immunization	No charge, **deductible** does not apply	Not covered	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. Frequency limitations apply.
If you have a test	**Diagnostic test** (x-ray, blood work)	No charge, **deductible** does not apply	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=select**	Standard Tier 1 (generic drugs)	20% **co-insurance**, pharmacy **deductible** does not apply.	20% **co-insurance**, pharmacy **deductible** does not apply.	Certain limitations apply. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Standard Tier 2 (preferred brand drugs)	30% **co-insurance**	30% **co-insurance**	
	Standard Tier 3 (non-preferred brand drugs)	40% **co-insurance**	40% **co-insurance**	
	Maintenance Tier 1 (generic drugs)	$10/prescription, pharmacy **deductible** does not apply.	$10/prescription, pharmacy **deductible** does not apply.	
	Maintenance Tier 2 (preferred brand drugs)	$50/prescription	$50/prescription	
	Maintenance Tier 3 (non-preferred brand drugs)	$135/prescription	$135/prescription	
	Specialty drugs	20% **co-insurance**	20% **co-insurance**	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.

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

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**, 10% **co-insurance** for ambulatory surgical center	Not covered	----------None----------
	Physician/surgeon fees	20% **co-insurance**	Not covered	----------None----------
If you need immediate medical attention	**Emergency room services**	$250/visit then 20% **co-insurance**	$250/visit then 20% **co-insurance**	**Emergency room services** apply to in-network benefits.
	Emergency medical transportation	20% **co-insurance**	20% **co-insurance**	Emergencies only. **Emergency medical transportation** applies to in-network benefits.
	Urgent care	$50/visit, **deductible** does not apply	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.
	Physician/surgeon fee	20% **co-insurance**	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 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. Additional limitations and exclusions apply.
	Inpatient services	20% **co-insurance**	Not covered	
If you are pregnant	Office visits	$40/visit, **deductible** does not apply	Not covered	Cost sharing does not apply to **preventive services**. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply. Maternity care may include test and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% **co-insurance**	Not covered	Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be pre-authorized at the time the **provider** recommends the extended stay.
	Childbirth/delivery facility services	20% **co-insurance**	Not covered	

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

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.
	Rehabilitation services	$50/visit for outpatient, 20% **co-insurance** for inpatient	Not covered	Up to 40 days per **plan** 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	$50/visit	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Skilled nursing care	20% **co-insurance**	Not covered	Up to 60 days per **plan** year. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Durable medical equipment (DME)	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Hospice service	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
If your child needs dental or eye care	Children's eye exam	$50/visit, **deductible** does not apply	Not covered	**Preventive** benefits abide by the ACA and are covered at 100%. One routine eye exam covered per calendar year.
	Children's glasses	Not covered	Not covered	Glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered.

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

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortions/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • 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 • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S., except for **urgent care** • Orthotic and other corrective appliances for the foot • Services that are not **medically necessary** • Temporomandibular Joint (TMJ) services greater than $2,000 lifetime

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery, **preauthorization** required with limitations • Chiropractic care	• Private-duty nursing, **preauthorization** required with limitations • Routine eye care (adult)	• Routine foot care • Weight loss programs as part of a program approved by Select Health

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

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov; or contact the **Plan**. 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.

To contact Select Health Member Services, please call 800-538-5038 weekdays, TTY users should call 711, or visit us at selecthealth.org.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes **plans**, **health insurance** available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the **premium tax credit**.

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/materials.

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	$1,700
Specialist	$50
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,960**

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

The plan's overall deductible	$1,700
Specialist	$50
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

The plan's overall deductible	$1,700
Specialist	$50
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

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

Fair Treatment Notice

Select Health obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

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 Select Health Member Services at 800-538-5038 or Select Health 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 Select Health 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

English

ATTENTION: If you speak Spanish, free language assistance services are available to you. Call Select Health.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Select Health.

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 Select Health

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Select Health.

Korean

통지: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Select Health. 번호로 전화해 주십시오.

Nepali

ध्यान दिनुहोस्: तपाईले नेपाली बोल्ननुनुहुन्छ भने तपाईको नि म्ति भाषा सहायता सेवाहरू नि ःशुल्क रूपमा उपलब्ध छ। Select Health मा फोन गर्ननुनुहोस्।

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Select Health.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Select Health.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните Select Health.

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Amharic

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Serb-Croatian

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Arabic

تامدخ كل رفوتتسف، ببرع تدحتت تنك اذإ :هيبنت
ب لصتا .أناجم ةيوغلا ةدعاسملا Select Health.

Persian

تامدخ ،دينكيم تبحص ينک دراو ار نابز هب رگا :هجوت
اب .تسامش رايتخا رد ناگيار تروصب ،ينابز كمک
ديريگب سامت Select Health.

Thai

หมายเหตุ: หากคุณพูด ใส่ภาษา, การบริการภาษาโดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ Select Health

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

Select Health

Coverage Period: 09/01/2026 - 08/31/2027
Coverage for: Single/Family | Plan Type: HDHP HMO

TOOELE COUNTY SCHOOL DISTRICT

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?	**$3,400** person/**$6,800** family per **plan** 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. **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?	**$4,000** person/**$8,000** family.	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, 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 an in-network SelectHealth Share® **provider** visit **selecthealth.org/find-care** 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**.

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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)	$15/visit	Not covered	A different benefit may apply for major office surgery.
	Specialist visit (SCP)	$25/visit	Not covered	A different benefit may apply for major office surgery.
	Preventive care / **screening** / immunization	No charge, **deductible** does not apply.	Not covered	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. Frequency limitations 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=select**	Standard Tier 1 (generic drugs)	$7/prescription	$7/prescription	Certain limitations apply. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Standard Tier 2 (preferred brand drugs)	$21/prescription	$21/prescription	
	Standard Tier 3 (non-preferred brand drugs)	$42/prescription	$42/prescription	
	Maintenance Tier 1 (generic drugs)	$7/prescription	$7/prescription	
	Maintenance Tier 2 (preferred brand drugs)	$42/prescription	$42/prescription	
	Maintenance Tier 3 (non-preferred brand drugs)	$126/prescription	$126/prescription	
	Specialty drugs	$100/prescription	$100/prescription	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.

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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**, 10% **co-insurance** for ambulatory surgical center	Not covered	----------None----------
	Physician/surgeon fees	20% **co-insurance**	Not covered	----------None----------
If you need immediate medical attention	**Emergency room services**	$75/visit	$75/visit	**Emergency room services** apply to in-network benefits.
	Emergency medical transportation	20% **co-insurance**	20% **co-insurance**	Emergencies only. **Emergency medical transportation** applies to in-network benefits.
	Urgent care	$35/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.
	Physician/surgeon fee	20% **co-insurance**	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 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. Additional limitations and exclusions apply.
	Inpatient services	20% **co-insurance**	Not covered	
If you are pregnant	Office visits	$15/visit	Not covered	Cost sharing does not apply to **preventive services**. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply. Maternity care may include test and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% **co-insurance**	Not covered	Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be pre-authorized at the time the **provider** recommends the extended stay.
	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.
	Rehabilitation services	$25/visit for outpatient, 20% **co-insurance** for inpatient	Not covered	Up to 40 days per **plan** 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	$25/visit	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Skilled nursing care	20% **co-insurance**	Not covered	Up to 60 days per **plan** year. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Durable medical equipment (DME)	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Hospice service	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
If your child needs dental or eye care	Children's eye exam	$25/visit	Not covered	**Preventive** benefits abide by the ACA and are covered at 100%. One routine eye exam covered per calendar year.
	Children's glasses	Not covered	Not covered	Glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered.

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Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortions/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • 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 • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S., except for **urgent care** • Orthotic and other corrective appliances for the foot • Services that are not **medically necessary** • Temporomandibular Joint (TMJ) services greater than $2,000 lifetime

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery, **preauthorization** required with limitations • Chiropractic care	• Private-duty nursing, **preauthorization** required with limitations • Routine eye care (adult)	• Routine foot care • Weight loss programs as part of a program approved by Select Health

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

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov; or contact the **Plan**. 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.

To contact Select Health Member Services, please call 800-538-5038 weekdays, TTY users should call 711, or visit us at selecthealth.org.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes **plans**, **health insurance** available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the **premium tax credit**.

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.

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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	$3,400
Specialist	$25
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,400
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,160**

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

The plan's overall deductible	$3,400
Specialist	$25
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,400
Copayments	$100
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,600**

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

The plan's overall deductible	$3,400
Specialist	$25
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

Fair Treatment Notice

Select Health obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

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 Select Health Member Services at 800-538-5038 or Select Health 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 Select Health 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

English

ATTENTION: If you speak Spanish, free language assistance services are available to you. Call Select Health.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Select Health.

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 Select Health

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Select Health.

Korean

통지: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Select Health. 번호로 전화해 주십시오.

Nepali

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्ननुनुहुन्छ भने तपाईको नि म्ति भाषा सहायता सेवाहरू नि ःशुल्क रूपमा उपलब्ध छ। Select Health मा फोन गर्ननुनुहोस्।

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Select Health.

German

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Persian

تامدخ، دينكيم تبحص ينک دراو ار نابز هب رگا: هجوت
اب .تسامش رايتخا رد ناگيار تروصب، ينابز كمک
ديريگب سامت Select Health.

Thai

หมายเหตุ: หากคุณพูด ใส่ภาษา, การบริการภาษาโดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ Select Health

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