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?	**$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.

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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)	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.

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