Select Health

Select Health Med Silver 4500 - no deductible for office visits

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?	**$4,500** person/**$9,000** family in-network and **$18,200** person/**$36,400** family out-of-network per calendar Year.	Generally, you must pay all the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of deductible expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. Prescription drugs, **Preventive** Services, and office visits 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. **$2,500** per person for prescription drugs. There are no other specific **Deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$9,000** person/**$18,000** family in-network, **$91,000** person/**$182,000** family out-of-network per calendar year.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out–of–pocket limit?	**Premiums**, **balance-billed** charges, **preventive services**, healthcare this **plan** doesn't cover, and penalties for failure to obtain **preauthorization** for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. To find an in-network SelectHealth M**ed®** **provider visit selecthea**lth.org/findadoctor or call Member Services at 800-538-5038.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a provider for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/contracts?I33C0068.

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)	$30/visit	50% **co-insurance**	**Deductible** does not apply to in-network services.
	Specialist visit (SCP)	$50/visit	50% **co-insurance**	Certain limitations apply to allergy testing, treatment and serum. **Deductible** does not apply to in-network services.
	Preventive care / **screening** / immunization	No charge	50% **co-insurance**	Frequency limitations apply. You may have to pay for services that aren't **preventive**. Ask your **provider** if the services needed are **preventive**. Then check what your **plan** will pay for. **Deductible** does not apply to in-network services.
If you have a test	**Diagnostic test** (x-ray, blood work)	$0/visit	50% **co-insurance**	**Deductible** does not apply to in-network services.
	Imaging (CT/PET scans, MRIs)	$150/visit	50% **co-insurance**	----------None----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at selecthealth.rxeob.com/mdb/public/router?account=rxc_t5_sm_id_ds_25	Tier 1	$5/prescription	$5/prescription	Certain limitations apply. Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. Pharmacy **deductible** waived for tiers 1 and 2.
	Tier 2	$25/prescription	$25/prescription	
	Tier 3	$45/prescription	$45/prescription	
	Tier 4	$55/prescription	$55/prescription	
	Tier 5	50% **co-insurance**	50% **co-insurance**	
	Specialty drugs	50% **co-insurance**	50% **co-insurance**	Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% **co-insurance**	50% **co-insurance**	Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**.
	Physician/surgeon fees	30% **co-insurance**	50% **co-insurance**	Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**.
If you need immediate medical attention	**Emergency room services**	$600/visit	$600/visit	**Emergency room services** apply to in-network benefits.
	Emergency medical transportation	$300/visit	$300/visit	Emergencies only. **Emergency medical transportation** applies to in-network benefits.
	Urgent care	$50/visit	50% **co-insurance**	Applies to **urgent care** facilities only. **Deductible** does not apply to in-network services.
If you have a hospital stay	Facility fee (e.g., hospital room)	$650/day	50% **co-insurance**	Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. Up to a 5 day copay applies to inpatient.
	Physician/surgeon fee	30% **co-insurance**	50% **co-insurance**	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30/visit for office visits, 30% **co-insurance** for outpatient	50% **co-insurance** for office visits, 50% **co-insurance** for outpatient	Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. Additional limitations and exclusions apply. **Deductible** does not apply to in-network mental health office visits. Up to a 5 day copay applies to inpatient.
	Inpatient services	$650/day	50% **co-insurance**	
If you are pregnant	Office visits	$30/visit	50% **co-insurance**	**Deductible** does not apply to in-network services.
	Childbirth/delivery professional services	30% **co-insurance**	50% **co-insurance**	Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. Up to a 5 day copay applies to inpatient. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply.
	Childbirth/delivery facility services	$650/day	50% **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**	30% **co-insurance**	50% **co-insurance**	Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**.
	Rehabilitation services	$30/visit for outpatient, $50/stay for inpatient	50% **co-insurance** for outpatient, 50% **co-insurance** for inpatient	Up to 20 visits per year for outpatient therapies, combined. Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. Up to a 5 day copay applies to inpatient. **Deductible** does not apply to in-network outpatient services.
	Habilitation services	$50/visit	50% **co-insurance**	Up to 20 visits per year for outpatient therapies, combined. Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. **Deductible** does not apply to in-network outpatient services.
	Skilled nursing care	$650/day	50% **co-insurance**	Up to 30 days per calendar year. Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. Up to a 5 day copay applies to inpatient.
	Durable medical equipment (DME)	30% **co-insurance**	50% **co-insurance**	Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. A different benefit may apply to prosthetic devices.
	Hospice service	30% **co-insurance**	50% **co-insurance**	Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**.
If your child needs dental or eye care	Children's eye exam	No charge	50% **co-insurance**	Covered through age 18. **Deductible** does not apply to in-network services.
	Children's glasses	30% **co-insurance**	50% **co-insurance**	Covered through age 18. Corrective lenses or contacts, one set per year. Eyeglass frames one pair every year.
	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/contracts?I33C0068.

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 • Adult **preventive** eye exams • Bariatric surgery • Cosmetic, reconstructive or corrective services, except in limited circumstances • Dental care (adult/child), except in limited circumstances • Dental check-up	• Experimental and/or investigational services • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility treatment • Long-term care • Orthotic and other corrective appliances for the foot • Private Duty Nursing • Routine foot care • Services for which a third-party is or may be responsible	• Services that are not **medically necessary** • Temporomandibular Joint (TMJ) services

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care, up to 18 visits per calendar year • Hearing aids in limited circumstances	• Non-Emergency care when traveling outside the U.S. • Routine eye care (Adult)	• 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/contracts?I33C0068.

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 Idaho Department of Insurance, P.O. Box 83720, Boise, ID 83720-0043.

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/contracts?I33C0068.

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	$4,500
Specialist	$50
Hospital (facility)	$650
Other	30%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,500
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,260**

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

The plan's overall deductible	$4,500
Specialist	$50
Hospital (facility)	$650
Other	30%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	$4,500
Specialist	$50
Hospital (facility)	$650
Other	30%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,100
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

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

Non-Discrimination 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

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 तपाईंको 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

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Serb-Croatian

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

Arabic

تامدخ كل رفوتتسف ،ىبرع ثدحتت تنك اذإ :هيبنت ب لصتا .اًناجم ةيوغللا 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, การบริการภาษา โดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ Select Health

Select Health: 1-800-538-5038

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