# Value Benchmark Expanded Bronze Copay Plan

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

**Coverage Period: 01/01/2024 - 12/31/2024**
**Coverage for: Single/Family | Plan Type: HMO**

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

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** | 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?** | No. | You will have to meet the **deductible** before the **plan** pays for any services. |
| **Are there other deductibles for specific services?** | Yes. **$3,500** person/**$7,000** family 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?** | **$9,450** person/**$18,900** family in-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 Value® **provider** visit **selecthealth.org/findadoctor** or call Member Services at 800-538-5038. | This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a provider for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/contracts?I40A1982.

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) | $45/visit | Not covered | ----------None---------- |
| | **Specialist** visit (SCP) | $90/visit | Not covered | Certain limitations apply to allergy testing, treatment and serum. |
| | **Preventive** care / **screening** / immunization | No charge | Not covered | Frequency limitations apply. You may have to pay for services that aren't **preventive**. Ask your **provider** if the services needed are **preventive**. Then check what your **plan** will pay for. |
| **If you have a test** | **Diagnostic test** (x-ray, blood work) | $75/visit | Not covered | ----------None---------- |
| | Imaging (CT/PET scans, MRIs) | $750/visit | Not covered | ----------None---------- |
| **If you need drugs to treat your illness or condition More information about prescription drug coverage is available at selecthealth.rxeob.com/mdb_sh/public/router?account=rxc_t5_ut_ds_24** | Tier 1 | $15/prescription | $15/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. Tiers 3 and 4 Maintenance drugs must be filled with Intermountain Home Delivery Pharmacy. |
| | Tier 2 | $30/prescription | $30/prescription | |
| | Tier 3 | $125/prescription | $125/prescription | |
| | Tier 4 | 50% **co-insurance** | 50% **co-insurance** | |
| | Tier 5 | 50% **co-insurance** | 50% **co-insurance** | |
| | **Specialty drugs** | 50% **co-insurance** | Not covered | 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) | $1,200/visit, $600/visit for ambulatory surgical center | Not covered | Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. |
| | Physician/surgeon fees | $100/visit | Not covered | 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** | $1,500/visit | $1,500/visit | **Emergency room services** apply to in-network benefits. |
| | **Emergency medical transportation** | $250/visit | $250/visit | Emergencies only. **Emergency medical transportation** applies to in-network benefits. |
| | **Urgent care** | $70/visit | Not covered | Applies to **urgent care** facilities only. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $2,950/day | Not covered | Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. Up to a 3 day copay applies to inpatient. |
| | Physician/surgeon fee | No charge | Not covered | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $45/visit for office visits, $750/visit for outpatient | Not covered | Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. Additional limitations and exclusions apply. Up to a 3 day copay applies to inpatient. |
| | Inpatient services | $2,950/day | Not covered | |
| **If you are pregnant** | Office visits | $45/visit | Not covered | ----------None---------- |
| | Childbirth/delivery professional services | $45/visit | Not covered | Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. Up to a 3 day copay applies to inpatient. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply. |
| | Childbirth/delivery facility services | $2,950/day | Not covered | |

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/contracts?I40A1982.

| 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** | $90/visit | Not covered | Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. Up to 30 visits per calendar year. |
| | **Rehabilitation services** | $25/visit for outpatient, $90/stay for inpatient | Not covered | Up to 20 visits per year for outpatient therapies, combined. Up to 30 days per year for inpatient therapies, combined. Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. Up to a 3 day copay applies to inpatient. |
| | **Habilitation services** | $40/visit | Not covered | 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**. |
| | **Skilled nursing care** | $2,950/day | Not covered | 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 3 day copay applies to inpatient. |
| | **Durable medical equipment (DME)** | 50% **co-insurance** | Not covered | 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** | $90/visit | Not covered | Benefits may be denied or reduced for failure to obtain **preauthorization** when required with **out-of-network providers**. Up to 6 months every 3 years. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Not covered | Covered through age 18. |
| | Children's glasses | $90/visit | Not covered | Covered through age 18. Corrective lenses or contacts, one set per 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?I40A1982.

## 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<br>• Acupuncture<br>• Administrative services/charges<br>• Adult **preventive** eye exams<br>• Bariatric surgery<br>• Chiropractic Care<br>• Cosmetic, reconstructive or corrective services, except in limited circumstances<br>• Dental care (adult/child), except in limited circumstances | • Dental check-up (Adult)<br>• Experimental and/or investigational services<br>• Eyeglass frames<br>• Hearing aids<br>• Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever<br>• Infertility treatment<br>• Long-term care<br>• Non-Emergency care when traveling outside the U.S. | • Orthotic and other corrective appliances for the foot<br>• Private Duty Nursing<br>• Services for which a third-party is or may be responsible<br>• Services that are not **medically necessary**<br>• Temporomandibular Joint (TMJ) services |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Routine eye care (Adult)<br>• Routine foot care, covered in limited circumstances | • 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?I40A1982.

## 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/contracts?I40A1982.

## 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** **$0**
- **Specialist** **$90**
- **Hospital (facility)** **$2,950**
- **Other** **$1,200**

**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 | $0 |
| Copayments | $6,500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$6,560** |

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

- **The plan's overall deductible** **$0**
- **Specialist** **$90**
- **Hospital (facility)** **$2,950**
- **Other** **$1,200**

**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 | $0 |
| Copayments | $1,800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,820** |

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

- **The plan's overall deductible** **$0**
- **Specialist** **$90**
- **Hospital (facility)** **$2,950**
- **Other** **$1,200**

**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 | $0 |
| Copayments | $1,900 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,000** |

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: 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.

**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 ،ربرع ثدحتت 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

**Select Health: 1-800-538-5038**

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