Nebo
SCHOOL DISTRICT

Group Health Plan

Annual Required Legal Notices and Disclosures for Plan Participants

List of Notices and Disclosures

HIPAA Notice of Privacy Practices

HIPAA Special Enrollment Notice

Medicare Part D Notice of Creditable Rx Coverage

Model Wellness Program Notice/Disclosure

Medical Carrier Summary of Benefits and Coverage (SBC)

If you want additional information on any of these notices or the benefits they address, contact Ryan Kay, Coordinator of Human Resources at (801) 354-7400 or ryan.kay@nebo.edu.

HIPAA Notice of Privacy Practices

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Effective date of this Privacy Notice is: September 1, 2018

If you have questions or want to file a complaint, contact the Employer's Privacy Officer:

Ryan Kay, Coordinator of Human Resources
(801) 354-7400 or ryan.kay@nebo.edu

PHI

What is Protected Health Information (PHI)?

PHI means individually identifiable health information, as defined by HIPAA, that is created or received by a medical provider or the plan or an insurance company that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Your Rights

You have the right to:

- Get a copy of your protected health information
- Correct your protected health information
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Our Uses and Disclosures

We may use and share your information as we:

- Administer the group health plan
- Pay for your health services or help resolve claims issues
- Comply with the law
- Respond to lawsuits and legal actions
- Address workers' compensation, law enforcement, and other government requests
- Help with public health and safety issues

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your protected health information

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

Ask us to correct your protected health information

- You can ask us to correct your protected health information that the plan has, if you think it is 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 say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain protected health information for treatment, payment, or health plan operations.
- We are not required to agree to your request, and we may say "no".

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 protected 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.
- If you want an accounting from your health insurer, you must request that directly from them. The employer Privacy Officer will only have a list of protected health information the plan sponsor shared in operating the plan or resolving payment issues.

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 us using the information on page 1
- 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.

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Pay for your health services

- We can request, use and disclose your PHI as we pay for your health services or help resolve claims at your request.
- *For example, if we offer a Health FSA, we (through the FSA Administrator) may use information about your medical services to process and pay claims.*

Health Care (Plan) Operations

- We can use and disclose your information to administer and manage the group health plan.
- *For example, this may include activities relating to the creation, renewal, or replacement of your group health plan coverage, business management, and other functions related to your group health plan. If any part of the plan is self insured, we also may use PHI for activities relating to reinsurance, auditing, and quality improvement.*
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

Family and Friends Involved in Your Care

- If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals.
- *For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.*

Business Associates

- The group health plan sometimes contracts with third parties or organizations to help administer or manage the plan or to provide services for the plan.
- *For example, we might contract with vendors to help process and pay your claims, or to review utilization of services. These venders are called "business associates," and we will provide PHI to them only if we have a signed "business associate agreement" in place with them.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations, although it is really the insurer not the plan sponsor who would have relevant health information:

- Public health issues – preventing the spread of disease
- Helping with product recalls of medical devices
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research, although the plan rarely if ever uses it for this purpose.

Our Uses and Disclosures

Continued…

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual die

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

The health plan does not sell your information or use it for marketing purposes. If the plan ever wanted to in the future, we could not unless you give us permission.

Our Responsibilities.

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We 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.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

HIPAA Special Enrollment Notice

This notice explains your right to enroll in or make changes to your group health insurance coverage mid-year.

Loss of Other Coverage
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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), except as specified below for Medicaid or CHIP coverage.

Marriage, Birth or Adoption
In addition, 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Medicaid or CHIP Coverage
If you or your dependents become eligible to participate in a Medicaid or Children's Health Insurance Plan (CHIP) premium assistance program, you may enroll for coverage under our health plan if you notify the plan administrator within 60 days after you become eligible to participate in Medicaid or CHIP.

If you or your dependents lose coverage under a Medicaid or CHIP premium assistance program due to loss of eligibility, you may enroll in our health plan if you apply to enroll within sixty (60) days of the loss of coverage under Medicaid or CHIP. If you enroll within sixty (60) days, the effective date of coverage is the first day after your Medicaid or CHIP coverage ended.

To request special enrollment or obtain more information, contact the Plan Administrator at (801) 354-7400 or ryan.kay@nebo.edu.

Medicare Part D Notice of Creditable Coverage

Important Notice from Nebo School District About Your Prescription Drug Coverage and Medicare

If you or your dependents are not eligible for Medicare, you may disregard this notice.

This notice applies to those covered under the Nebo School District Benefit Plan. Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with our Benefit Plan 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 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. Nebo School District has determined that the prescription drug coverage offered by the Nebo School District Medical Plan is, on average for all plan participants, expected to pay out 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 drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Nebo School District coverage will not be affected. Medicare eligible individuals who become eligible for Medicare Part D can keep this coverage if they elect Part D and this plan will pay primary to Medicare Part D coverage. If you do decide to join a Medicare drug plan and drop your current coverage under our plan, be aware that you and your dependents will not be able to get back this coverage back except at the next annual open enrollment or if you have a "special enrollment" event.

Medicare Part D Notice of Creditable Coverage

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Nebo School District and don't join a Medicare 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 the person at the number listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Nebo School District Plan 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 Social Security on the web at www.socialsecurity.gov, or call them 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 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).

Date:	September 1, 2018
Name of Entity/Sender:	Nebo School District
Contact--Position/Office:	Ryan Kay – Coordinator of Human Resources
Email Address:	ryan.kay@nebo.edu
Phone Number:	(801) 354-7400

NOTICE REGARDING WELLNESS PROGRAM

Engaged in Wellness is a voluntary wellness program available to employees enrolled on Nebo School District's health insurance. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, there are two requirements you will you be asked to complete. First, an employee will be asked to provide documentation showing completion of a preventative exam, or provide proof that shows an employee is current on a preventative exam. The employee will work with his or her health care provider to determine the frequency of completing a physical examination, cancer screenings, blood chemistry panel, immunizations and professional interventions or lifestyle changes. Second, an employee must complete the educational course requirements found on Nebo's Canvas portal.

You are not required to complete the Engaged in Wellness program; however, employees enrolled on Nebo School District Health Insurance who choose to complete the Engaged in Wellness program will not have a pay deduction of $200. You must complete the Engaged in Wellness requirements listed above before February 1, 2019 in order to avoid the pay deduction. This deduction, which will be in $40 increments, will be effective from February 2019 to June 2019. For all details, please see: http://wellness.nebo.edu/

Nebo School District also offers a voluntary incentive program, Gimme 5. This incentive is available to all employees who are eligible to enroll on Nebo School District Health Insurance. Employees will be asked to complete five requirements. Upon completion, an employee can choose between prizes, which features a "wellness day", $50 Gift card, RTIC drinkware and fit watch. You must complete the Gimme 5 program before May 5, 2019 to be eligible for one of the incentives listed above. For all details, please see: http://wellness.nebo.edu/ (IRS Tax Memo: Some financial incentives will be subject to income tax for the employee who receives this benefit/incentive).

Employees will be eligible to be entered into a "shoe coupon" drawing. In order to be eligible, an employee must successfully report monthly activities by completing "My Right Care". If you are unable to participate in any of the health-related activities you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting John Allan at 801-354-7466.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Nebo School District may use aggregate information it collects to design a program based on identified health risks in the workplace, Engaged in Wellness will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed, except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) your health care providers, GBS Benefits, and Deerwalk, in order to provide you with optimal support and services under the wellness program. Your personal health information is HIPAA protected and will remain otherwise confidential; your employer, Nebo School District, will not have access to this data.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact John Allan at 801-354-7466.

selecthealth **NEBO SCHOOL DISTRICT**

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

Coverage Period: 09/01/2018 - 08/31/2019
Coverage for: Single/Family | Plan Type: HDHP HMO

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,600** single/**$3,200** 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 and **preventive** prescriptions 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?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$3,250** single/**$6,500** 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 pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. To find a participating SelectHealth Share® **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/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)	20% **co-insurance**	Not covered	A different benefit may apply for major office surgery.
	Specialist visit (SCP)	20% **co-insurance**	Not covered	Certain limitations apply to allergy testing, treatment and serum. A different benefit may apply for major office surgery.
	Preventive care / **screening** / immunization	No charge	Not covered	Frequency limitations apply. **Deductible** does not apply.
If you have a test	**Diagnostic test** (x-ray, blood work)	No charge	Not covered	----------None----------
	Imaging (CT/PET scans, MRIs)	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)	$10/prescription	$10/prescription	Certain limitations apply. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services. **Deductible** does not apply to **preventive** prescriptions.
	Standard Tier 2 (preferred brand drugs)	$25/prescription	$25/prescription	
	Standard Tier 3 (non-preferred brand drugs)	$50/prescription	$50/prescription	
	Maintenance Tier 1 (generic drugs)	$10/prescription	$10/prescription	
	Maintenance Tier 2 (preferred brand drugs)	$50/prescription	$50/prescription	
	Maintenance Tier 3 (non-preferred brand drugs)	$150/prescription	$150/prescription	
	Specialty drugs	20% **co-insurance** for medical, $100/prescription for pharmacy	Not covered for medical, $100/prescription for pharmacy	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**	Not covered	----------None----------
	Physician/surgeon fees	20% **co-insurance**	Not covered	----------None----------
If you need immediate medical attention	**Emergency room services**	20% **co-insurance**	20% **co-insurance**	**Emergency room services** apply to participating benefits.
	Emergency medical transportation	20% **co-insurance**	20% **co-insurance**	Emergencies only. **Emergency medical transportation** applies to participating benefits.
	Urgent care	20% **co-insurance**	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	Outpatient services	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services. Additional limitations and exclusions
	Inpatient services	20% **co-insurance**	Not covered	
If you are pregnant	Office visits	20% **co-insurance**	Not covered	A different benefit may apply for major office surgery.
	Childbirth/delivery professional services	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply.
	Childbirth/delivery facility services	20% **co-insurance**	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**	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Rehabilitation services	20% **co-insurance**	Not covered	Up to 20 visits per **plan** year for each therapy type for outpatient physical, speech, and occupational therapy. 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	Not covered	Not covered	Habilitation is not covered.
	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	20% **co-insurance**	Not covered	----------None----------
	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 Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Abortions/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • Autism spectrum disorder services greater than $30,000 or 600 hours, whichever is greater • Bariatric surgery • Chiropractic care • Cochlear implants without **preauthorization** • Complications of a non-covered service for the 1st year after the original date of service • 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 • Habilitation services • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility (select services) greater than $1,500 per year and $5,000 per lifetime • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S., except for **urgent care** • Organ transplants if not preauthorized • Orthotic and other corrective appliances for the foot • Services for which a third-party is or may be responsible • Services related to certain illegal activities • 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.		
• Private Duty Nursing, requires **preauthorization** with limitations • Routine eye care (adult)	• Routine foot care • Weight loss programs as part of a program approved by SelectHealth	

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/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: Utah Insurance Department, Office of Consumer Assistance, Suite 3110, State Office Building, Salt Lake City, Utah 84114. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance **Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call 1-800-318-2596.

Your Grievance and Appeals Rights:

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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	$1,600
Specialist	20%
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$1,650
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,310**

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

The plan's overall deductible	$1,600
Specialist	20%
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$635
Coinsurance	$558
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,848**

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

The plan's overall deductible	$1,600
Specialist	20%
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	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,540
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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

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Korean

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Navajo

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę'ę", t'áá jiik'eh, éí ná hóló', kojį' hódíílnih SelectHealth: **800-538-5038**.

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Tongan

FAKATOKANGA'I: Kapau 'oku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta'etotongi, pea te ke lava 'o ma'u ia. Telefoni ki he SelectHealth: **800-538-5038**.

Serb-Croatian

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите SelectHealth: **800-538-5038**.

Tagalog

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Arabic

ةظوحلم: ةدعاسملا تامدخ نإف ،ةيبرعلا تدحتت تنك اذإ. ناجملاب كل رفاوتت ةيوغللا ةكرشب لصتا SelectHealth: **800-538-5038**

Mon-khmer, Cambodian

សម្គាល់៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់ អ្នក។ សូមទូរស័ព្ទមក SelectHealth: **800-538-5038** ។

French

ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth: **800-538-5038**.

Japanese

注意事項：日本語を話される場合、無料の言語 支援をご利用いただけます。SelectHealth: **800-538-5038**. まで、お電話にてご連絡ください。

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selecthealth **NEBO SCHOOL DISTRICT**

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

Coverage Period: 09/01/2018 - 08/31/2019
Coverage for: Single/Family | Plan Type: HDHP HMO

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,600** single/**$3,200** 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 and **preventive** prescriptions 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?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$1,600** single/**$3,200** 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 pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. To find a participating SelectHealth Share® **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**.

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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)	No charge	Not covered	A different benefit may apply for major office surgery.
	Specialist visit (SCP)	No charge	Not covered	Certain limitations apply to allergy testing, treatment and serum. A different benefit may apply for major office surgery.
	Preventive care / **screening** / immunization	No charge	Not covered	Frequency limitations apply. **Deductible** does not apply.
If you have a test	**Diagnostic test** (x-ray, blood work)	No charge	Not covered	----------None----------
	Imaging (CT/PET scans, MRIs)	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. **Deductible** does not apply to **preventive** prescriptions.
	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 for medical, no charge for pharmacy	Not covered for medical, no charge for pharmacy	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 participating benefits.
	Emergency medical transportation	No charge	No charge	Emergencies only. **Emergency medical transportation** applies to participating 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 for office visits, no charge 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	No charge	Not covered	
If you are pregnant	Office visits	No charge	Not covered	A different benefit may apply for major office surgery.
	Childbirth/delivery professional services	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply.
	Childbirth/delivery facility services	No charge	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**	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Rehabilitation services	No charge for outpatient, No charge for inpatient	Not covered	Up to 20 visits per **plan** year for each therapy type for outpatient physical, speech, and occupational therapy. 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	Not covered	Not covered	Habilitation is not covered.
	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	----------None----------
	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 Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Abortions/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • Autism spectrum disorder services greater than $30,000 or 600 hours, whichever is greater • Bariatric surgery • Chiropractic care • Cochlear implants without **preauthorization** • Complications of a non-covered service for the 1st year after the original date of service • 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 • Habilitation services • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility (select services) greater than $1,500 per year and $5,000 per lifetime • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S., except for **urgent care** • Organ transplants if not preauthorized • Orthotic and other corrective appliances for the foot • Services for which a third-party is or may be responsible • Services related to certain illegal activities • 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.		
• Private Duty Nursing, requires **preauthorization** with limitations • Routine eye care (adult)	• Routine foot care • Weight loss programs as part of a program approved by SelectHealth	

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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**.

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(9 months of in-network pre-natal care and a hospital delivery)

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Specialist office visits (*prenatal care)*
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Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,660**

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

The plan's overall deductible	$1,600
Specialist	Covered 100%
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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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,655**

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

The plan's overall deductible	$1,600
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	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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Arabic

ةظوحلم: ةدعاسملا تامدخ نإف ،ةيبرعلا تدحتت تنك اذإ. ناجملاب كل رفاوتت ةيوغللا ةكرشب لصتا SelectHealth: **800-538-5038**

Mon-khmer, Cambodian

សម្គាល់៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់ អ្នក។ សូមទូរស័ព្ទមក SelectHealth: **800-538-5038** ។

French

ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth: **800-538-5038**.

Japanese

注意事項：日本語を話される場合、無料の言語 支援をご利用いただけます。SelectHealth: **800-538-5038**. まで、お電話にてご連絡ください。

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

selecthealth **NEBO SCHOOL DISTRICT**

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

Coverage Period: 09/01/2018 - 08/31/2019
Coverage for: Single/Family | Plan Type: HDHP 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?	**$2,700** person/**$5,400** 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 **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 and **preventive** prescriptions 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?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$3,700** person/**$7,400** 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 pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. To find a participating SelectHealth Share® **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/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)	20% **co-insurance**	Not covered	A different benefit may apply for major office surgery.
	Specialist visit (SCP)	20% **co-insurance**	Not covered	Certain limitations apply to allergy testing, treatment and serum. A different benefit may apply for major office surgery.
	Preventive care / **screening** / immunization	No charge	Not covered	Frequency limitations apply. **Deductible** does not apply.
If you have a test	**Diagnostic test** (x-ray, blood work)	No charge	Not covered	----------None----------
	Imaging (CT/PET scans, MRIs)	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)	$10/prescription	$10/prescription	Certain limitations apply. Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services. **Deductible** does not apply to **preventive** prescriptions.
	Standard Tier 2 (preferred brand drugs)	$25/prescription	$25/prescription	
	Standard Tier 3 (non-preferred brand drugs)	$50/prescription	$50/prescription	
	Maintenance Tier 1 (generic drugs)	$10/prescription	$10/prescription	
	Maintenance Tier 2 (preferred brand drugs)	$50/prescription	$50/prescription	
	Maintenance Tier 3 (non-preferred brand drugs)	$150/prescription	$150/prescription	
	Specialty drugs	20% **co-insurance** for medical, $100/prescription for pharmacy	Not covered for medical, $100/prescription for pharmacy	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**	Not covered	----------None----------
	Physician/surgeon fees	20% **co-insurance**	Not covered	----------None----------
If you need immediate medical attention	**Emergency room services**	20% **co-insurance**	20% **co-insurance**	**Emergency room services** apply to participating benefits.
	Emergency medical transportation	20% **co-insurance**	20% **co-insurance**	Emergencies only. **Emergency medical transportation** applies to participating benefits.
	Urgent care	20% **co-insurance**	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	Outpatient services	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services. Additional limitations and exclusions
	Inpatient services	20% **co-insurance**	Not covered	
If you are pregnant	Office visits	20% **co-insurance**	Not covered	A different benefit may apply for major office surgery.
	Childbirth/delivery professional services	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply.
	Childbirth/delivery facility services	20% **co-insurance**	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**	20% **co-insurance**	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Rehabilitation services	20% **co-insurance**	Not covered	Up to 20 visits per **plan** year for each therapy type for outpatient physical, speech, and occupational therapy. 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	Not covered	Not covered	Habilitation is not covered.
	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	20% **co-insurance**	Not covered	----------None----------
	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 Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Abortions/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • Autism spectrum disorder services greater than $30,000 or 600 hours, whichever is greater • Bariatric surgery • Chiropractic care • Cochlear implants without **preauthorization** • Complications of a non-covered service for the 1st year after the original date of service • 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 • Habilitation services • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility (select services) greater than $1,500 per year and $5,000 per lifetime • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S., except for **urgent care** • Organ transplants if not preauthorized • Orthotic and other corrective appliances for the foot • Services for which a third-party is or may be responsible • Services related to certain illegal activities • 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.		
• Private Duty Nursing, requires **preauthorization** with limitations • Routine eye care (adult)	• Routine foot care • Weight loss programs as part of a program approved by SelectHealth	

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/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: Utah Insurance Department, Office of Consumer Assistance, Suite 3110, State Office Building, Salt Lake City, Utah 84114. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance **Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your plan documents also provide complete information to submit a claim, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform or If your coverage is fully-insured, you may also contact the Utah Insurance Department, Office of Consumer Assistance, Suite 3110, State Office Building, Salt Lake City, Utah 84114.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next page.*

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/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	$2,700
Specialist	20%
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,760**

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

The plan's overall deductible	$2,700
Specialist	20%
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$497
Coinsurance	$503
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,755**

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

The plan's overall deductible	$2,700
Specialist	20%
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	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,540
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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

Non-Discrimination Notice

SelectHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free aid and services to people with disabilities to help them communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). We also provide free language services to people whose primary language is not English, such as qualified interpreters and member materials written in other languages.

If you need these services, please call SelectHealth Member Services at 800-538-5038 or SelectHealth Advantage Member Service at 855-442-9900. Any member or other person who believes he/she may have been subject to discrimination may file a complaint or grievance by calling the SelectHealth 504/Civil Rights Coordinator at 844-208-9012 or the Compliance Hotline at 800-442-4845 (TTY Users: 711). You may also call the Office for Civil Rights at 1-800-368-1019 (TTY Users: 800-537-7697).

Language Access Services

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth: **800-538-5038.**

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 SelectHealth: **800-538-5038**. 。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth: **800-538-5038**.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth: **800-538-5038**. 번으로 전화해 주십시오.

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę'ę", t'áá jiik'eh, éí ná hóló', kojį' hódíílnih SelectHealth: **800-538-5038**.

Nepali

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । SelectHealth: **800-538-5038** मा फोन गर्नुहोस्।

Tongan

FAKATOKANGA'I: Kapau 'oku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta'etotongi, pea te ke lava 'o ma'u ia. Telefoni ki he SelectHealth: **800-538-5038**.

Serb-Croatian

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите SelectHealth: **800-538-5038**.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth: **800-538-5038**.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth: **800-538-5038**.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth: **800-538-5038**

Arabic

ةظوحلم: ةدعاسملا تامدخ نإف ،ةيبرعلا تدحتت تنك اذإ. ناجملاب كل رفاوتت ةيوغللا ةكرشب لصتا SelectHealth: **800-538-5038**

Mon-khmer, Cambodian

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selecthealth **NEBO SCHOOL DISTRICT**

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

Coverage Period: 09/01/2018 - 08/31/2019
Coverage for: Single/Family | Plan Type: HDHP 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?	**$2,700** person/**$5,400** 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 **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 and **preventive** prescriptions 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?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$2,700** person/**$5,400** 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 pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. To find a participating SelectHealth Share® **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/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	Certain limitations apply to allergy testing, treatment and serum. A different benefit may apply for major office surgery.
	Preventive care / **screening** / immunization	No charge	Not covered	Frequency limitations apply. **Deductible** does not apply.
If you have a test	**Diagnostic test** (x-ray, blood work)	No charge	Not covered	----------None----------
	Imaging (CT/PET scans, MRIs)	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. **Deductible** does not apply to **preventive** prescriptions.
	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 for medical, no charge for pharmacy	Not covered for medical, no charge for pharmacy	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 participating benefits.
	Emergency medical transportation	No charge	No charge	Emergencies only. **Emergency medical transportation** applies to participating 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 for office visits, no charge 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	No charge	Not covered	
If you are pregnant	Office visits	No charge	Not covered	A different benefit may apply for major office surgery.
	Childbirth/delivery professional services	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply.
	Childbirth/delivery facility services	No charge	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**	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Rehabilitation services	No charge for outpatient, No charge for inpatient	Not covered	Up to 20 visits per **plan** year for each therapy type for outpatient physical, speech, and occupational therapy. 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	Not covered	Not covered	Habilitation is not covered.
	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	----------None----------
	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 Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Abortions/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • Autism spectrum disorder services greater than $30,000 or 600 hours, whichever is greater • Bariatric surgery • Chiropractic care • Cochlear implants without **preauthorization** • Complications of a non-covered service for the 1st year after the original date of service • 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 • Habilitation services • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility (select services) greater than $1,500 per year and $5,000 per lifetime • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S., except for **urgent care** • Organ transplants if not preauthorized • Orthotic and other corrective appliances for the foot • Services for which a third-party is or may be responsible • Services related to certain illegal activities • 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.		
• Private Duty Nursing, requires **preauthorization** with limitations • Routine eye care (adult)	• Routine foot care • Weight loss programs as part of a program approved by SelectHealth	

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/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: Utah Insurance Department, Office of Consumer Assistance, Suite 3110, State Office Building, Salt Lake City, Utah 84114. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance **Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your plan documents also provide complete information to submit a claim, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform or If your coverage is fully-insured, you may also contact the Utah Insurance Department, Office of Consumer Assistance, Suite 3110, State Office Building, Salt Lake City, Utah 84114.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next page.*

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/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	$2,700
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,760**

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

The plan's overall deductible	$2,700
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,755**

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

The plan's overall deductible	$2,700
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	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,925
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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

NEBO SCHOOL DISTRICT OPTION 5
4/2/2018

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

Non-Discrimination Notice

SelectHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free aid and services to people with disabilities to help them communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). We also provide free language services to people whose primary language is not English, such as qualified interpreters and member materials written in other languages.

If you need these services, please call SelectHealth Member Services at 800-538-5038 or SelectHealth Advantage Member Service at 855-442-9900. Any member or other person who believes he/she may have been subject to discrimination may file a complaint or grievance by calling the SelectHealth 504/Civil Rights Coordinator at 844-208-9012 or the Compliance Hotline at 800-442-4845 (TTY Users: 711). You may also call the Office for Civil Rights at 1-800-368-1019 (TTY Users: 800-537-7697).

Language Access Services

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth: **800-538-5038.**

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 SelectHealth: **800-538-5038**. 。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth: **800-538-5038**.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth: **800-538-5038**. 번으로 전화해 주십시오.

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę'ę", t'áá jiik'eh, éí ná hóló', kojį' hódíílnih SelectHealth: **800-538-5038**.

Nepali

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । SelectHealth: **800-538-5038** मा फोन गर्नुहोस्।

Tongan

FAKATOKANGA'I: Kapau 'oku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta'etotongi, pea te ke lava 'o ma'u ia. Telefoni ki he SelectHealth: **800-538-5038**.

Serb-Croatian

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите SelectHealth: **800-538-5038**.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth: **800-538-5038**.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth: **800-538-5038**.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth: **800-538-5038**

Arabic

ةظوحلم: ةدعاسملا تامدخ نإف ،ةيبرعلا تدحتت تنك اذإ. ناجملاب كل رفاوتت ةيوغللا ةكرشب لصتا SelectHealth: **800-538-5038**

Mon-khmer, Cambodian

សម្គាល់៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់ អ្នក។ សូមទូរស័ព្ទមក SelectHealth: **800-538-5038** ។

French

ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth: **800-538-5038**.

Japanese

注意事項：日本語を話される場合、無料の言語 支援をご利用いただけます。SelectHealth: **800-538-5038**. まで、お電話にてご連絡ください。

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