Nebo
SCHOOL DISTRICT

2022 Group Health Plan Notices

Annual Required Legal Notices and Disclosures for Plan Participants

The following notices provide important information about your employer provided group health plan. Please read the notices carefully and keep a copy for your records. If you have any questions regarding these notices, please contact Human Resources or the plan administrator at ryan.kay@nebo.edu or (801) 354-7400.

Medicare Part D Notice

Important Notice About Your Prescription Drug Coverage and Medicare

Individual CREDITABLE Coverage Disclosure

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

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

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

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

What happens to your current coverage if you decide to join a Medicare prescription drug plan?

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

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

Your medical benefits brochure contains a description of your current prescription drug benefits.

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

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

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

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

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

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

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

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

Required Notices

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion.
- Loss of other coverage [(1)].
- Acquisition of a new spouse or dependent through marriage [(1)], adoption [(1)], placement for adoption [(1)] or birth [(1)].
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families)(60-day notice) [(1)].
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-daynotice).

"Change in Status" Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.
- Examples of permitted "change in status" events include:
- Change in legal marital status (e.g., marriage [(2)], divorce or legal separation)
- Change in number of dependents (e.g., birth [(2)], adoption [(2)] or death)
- Change in eligibility of a child
- Change in your / your spouse's / your state registered / unregistered / state registered and unregistered domestic partner's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's / your state registered / unregistered / state registered and unregistered domestic partner's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage [(3)]
- Loss of other coverage
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
- You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

HIPAA Privacy Notice

Notice of Health Information Privacy Practices

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

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). One of its primary purposes is to make certain that information about your health is handled with special respect for your privacy. HIPAA includes numerous provisions designed to maintain the privacy and confidentiality of your protected health information (PHI). PHI is health information that contains identifiers, such as your name, address, social security number, or other information that identifies you.

Our Pledge Regarding Health Information

- We understand that health information about you and your health is personal.
- We are committed to protecting health information about you.
- This notice will tell you the ways in which we may use and disclose health information about you.
- We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are Required by Law to

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you;
- Follow the terms of the notice that are currently in effect.

The Plan Will Use Your Health Information for

Treatment: The plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associate agreements are maintained with insurance carriers. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy and security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

Workers' Compensation: We may release health information about you for Workers' Compensation or

similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement: We may disclose your health information for law enforcement purposes, or in response to a valid subpoena or other judicial or administrative request.

Public Health: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation).

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information, where concerning a service already paid for;
- Obtain a paper copy of the Notice of Health Information Practices by requesting it from the plan privacy officer;
- Inspect and obtain a copy of your health information;
- Request an amendment to your health information;
- Obtain an accounting of disclosures of your health information;
- Request communications of your health information be sent in a different way or to a different place than usual (for example, you could request that the envelope be marked "Confidential" or that we send it to your work address rather than your home address);
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.

The Plan's Responsibilities

The plan is required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we
- collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction, amendment or other request;
- Notify you of any breaches of your personal health information within 60 days or 5 days if conducting business in California;
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you.

1) Indicates that this event is also a qualified "Change in Status"
2) Indicates this event is also a HIPAA Special Enrollment Right
3) Indicates that this event is also a COBRA Qualifying Event

For More Information or to Repot a Problem

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer; or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you authorize us to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the payment activities that we provided to you.

Important Information on How Health Care Reform Affects Your Plan

Prohibition on Excess Waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Preexisting Condition Exclusion

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

Employee Rights & Responsibilities under the Family Medical Leave Act

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness [(1)]; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. [(1)]

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

1) The FMLA definitions of “serious injury or illness” for current service members and veterans are distinct from the FMLA definition of “serious health condition”.
2) Special hours of service eligibility requirements apply to airline flight crew employees.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months (2), and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627 www.wagehour.dol.gov.

Uniformed Services Employment & Reemployment Rights Act Notice of 1994, Notice of Right to Continued Coverage under USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You Do Not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

We will not provide advance notice to you when your continuation coverage terminates.

Reporting to Work/Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible.
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible.
181 days or more	Submit an application for reemployment within 90 days after completion of your service.
Any period if for purposes of an examination for fitness to perform uniformed service.	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible.
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service.	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definition

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

Notice Regarding Wellness Programs

The Healthy Living program through Select Health is a voluntary wellness program available to all employees and spouses enrolled on Nebo School District's medical plan. 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, you will be asked to complete a voluntary online health assessment that asks a series of questions about your health-related activities and behaviors. You will also be asked to complete an onsite biometric screening or obtain a screening through a physician, which will include measuring blood pressure, body mass index, waist circumference and body fat percentage. The information from your health assessment and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as coaching programs or wellness challenges. You also are encouraged to share your results or concerns with your own doctor.

Employees and spouses enrolled in a Nebo District medical plan who choose to participate in the wellness program will be eligible to receive an incentive that includes a $100 contribution to the employee HSA account ($100 for employees and $100 for spouses). In order to receive the wellness incentive, employees and spouses must complete the following Healthy Living Share activities: Create a "My Health" account on selecthealth.org, select a Primary Care Physician, attend the onsite biometric screening or complete a screening though your physician, complete the online health assessment, complete at least one digital coaching journey, and complete at least two online activity campaigns. Although you are not required to complete the listed activities, only employees who do so will be eligible to receive the incentive. HSA contributions for successful completion will begin in January 2023 and have a deadline of April 1st, 2023. Employees who waive district health insurance or are non-benefited are also eligible for a wellness incentive, please contact human resources for more details on this.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Select Health.

For More Information or to Report a Problem

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer; or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you authorize us to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use

or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the payment activities that we provided to you.

Protection 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 use aggregate information it collects to design a program based on identified health risks in the workplace, Select Health / Healthy Living 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 individuals who may receive your personally identifiable health information are the biometric screeners, CareHere, and GBS' analytic partner, Deerwalk, in order to provide you with services under the wellness program.

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. In the event a data breach involving information you provide in connection with the wellness program occurs, 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 human resources.

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?	$2,800 person/$5,600 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 preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. To find an in-network SelectHealth Share® provider visit selecthealth.org/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 certain 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 in-network benefits.
	Emergency medical transportation	20% co-insurance	20% co-insurance	Emergencies only. Emergency medical transportation applies to in-network 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 abuse services	Outpatient services	20% co-insurance for office visits, 20% co-insurance for outpatient	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services. Additional limitations and exclusions apply.
	Inpatient services	20% co-insurance	Not covered	
If you are pregnant	Office visits	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	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Rehabilitation services	20% co-insurance for outpatient, 20% co-insurance for inpatient	Not covered	Up to 40 days per plan year for inpatient physical, speech, and occupational therapies combined. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Habilitation services	20% co-insurance	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Skilled nursing care	20% co-insurance	Not covered	Up to 60 days per plan year. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Durable medical equipment (DME)	20% co-insurance	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Hospice service	20% co-insurance	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
If your child needs dental or eye care	Children's eye exam	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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortions/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • Chiropractic care • Cosmetic surgery and reconstructive and corrective services, except in limited circumstances • Dental care (adult/child), except in limited circumstances • Dental check-up • Experimental and/or investigational services	• Glasses • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S., except for urgent care • Orthotic and other corrective appliances for the foot • Services 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.)		
• Bariatric surgery, preauthorization required with limitations • Private Duty Nursing, preauthorization required 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: 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 SelectHealth Member Services, please call 800-538-5038 weekdays, TTY users should call 711, or visit us at selecthealth.org.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

The plan's overall deductible	$2,800
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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$900
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	$2,800
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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$500
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$3,760

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

The plan's overall deductible	$2,800
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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,200
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,800

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

NEBO SCHOOL DISTRICT OPTION 1
4/25/2022

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

selecthealth NEBO SCHOOL DISTRICT

Coverage Period: 09/01/2022 - 08/31/2023

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

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?	$2,800 person/$5,600 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?	$2,800 person/$5,600 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, healthcare this plan doesn't cover, and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. To find an in-network SelectHealth Share® provider visit selecthealth.org/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 certain 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.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	----------None----------
	Physician/surgeon fees	No charge	Not covered	----------None----------
If you need immediate medical attention	Emergency room services	No charge	No charge	Emergency room services apply to in-network benefits.
	Emergency medical transportation	No charge	No charge	Emergencies only. Emergency medical transportation applies to in-network benefits.
	Urgent care	No charge	Not covered	Applies to urgent care facilities only.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Physician/surgeon fee	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge 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 40 days per plan year for inpatient physical, speech, and occupational therapies combined. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Habilitation services	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Skilled nursing care	No charge	Not covered	Up to 60 days per plan year. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Durable medical equipment (DME)	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Hospice service	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	----------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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortions/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • Chiropractic care • Cosmetic surgery and reconstructive and corrective services, except in limited circumstances • Dental care (adult/child), except in limited circumstances • Dental check-up • Experimental and/or investigational services	• Glasses • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S., except for urgent care • Orthotic and other corrective appliances for the foot • Services 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.)		
• Bariatric surgery, preauthorization required with limitations • Private Duty Nursing, preauthorization required 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: 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 SelectHealth Member Services, please call 800-538-5038 weekdays, TTY users should call 711, or visit us at selecthealth.org.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

The plan's overall deductible	$2,800
Specialist	Covered 100%
Hospital (facility)	Covered 100%
Other	Covered 100%

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

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,860

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

The plan's overall deductible	$2,800
Specialist	Covered 100%
Hospital (facility)	Covered 100%
Other	Covered 100%

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

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,860

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

The plan's overall deductible	$2,800
Specialist	Covered 100%
Hospital (facility)	Covered 100%
Other	Covered 100%

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

Total Example Cost	$2,800

In this example, Mia would pay:

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

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

NEBO SCHOOL DISTRICT OPTION 1
4/25/2022

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

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 preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. To find an in-network SelectHealth Share® provider visit selecthealth.org/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 certain 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 in-network benefits.
	Emergency medical transportation	20% co-insurance	20% co-insurance	Emergencies only. Emergency medical transportation applies to in-network 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 abuse services	Outpatient services	20% co-insurance for office visits, 20% co-insurance for outpatient	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services. Additional limitations and exclusions apply.
	Inpatient services	20% co-insurance	Not covered	
If you are pregnant	Office visits	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	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Rehabilitation services	20% co-insurance for outpatient, 20% co-insurance for inpatient	Not covered	Up to 40 days per plan year for inpatient physical, speech, and occupational therapies combined. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Habilitation services	20% co-insurance	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Skilled nursing care	20% co-insurance	Not covered	Up to 60 days per plan year. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Durable medical equipment (DME)	20% co-insurance	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Hospice service	20% co-insurance	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
If your child needs dental or eye care	Children's eye exam	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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortions/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • Chiropractic care • Cosmetic surgery and reconstructive and corrective services, except in limited circumstances • Dental care (adult/child), except in limited circumstances • Dental check-up • Experimental and/or investigational services	• Glasses • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S., except for urgent care • Orthotic and other corrective appliances for the foot • Services 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.)		
• Bariatric surgery, preauthorization required with limitations • Private Duty Nursing, preauthorization required 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: 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 SelectHealth Member Services, please call 800-538-5038 weekdays, TTY users should call 711, or visit us at selecthealth.org.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

The plan's overall deductible	$1,600
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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,360

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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$600
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,660

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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,200

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

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

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 preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. To find an in-network SelectHealth Share® provider visit selecthealth.org/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 certain 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.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	----------None----------
	Physician/surgeon fees	No charge	Not covered	----------None----------
If you need immediate medical attention	Emergency room services	No charge	No charge	Emergency room services apply to in-network benefits.
	Emergency medical transportation	No charge	No charge	Emergencies only. Emergency medical transportation applies to in-network benefits.
	Urgent care	No charge	Not covered	Applies to urgent care facilities only.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Physician/surgeon fee	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge 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 40 days per plan year for inpatient physical, speech, and occupational therapies combined. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Habilitation services	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Skilled nursing care	No charge	Not covered	Up to 60 days per plan year. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Durable medical equipment (DME)	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Hospice service	No charge	Not covered	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	----------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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortions/termination of pregnancy except in limited circumstances • Acupuncture • Administrative services/charges • Chiropractic care • Cosmetic surgery and reconstructive and corrective services, except in limited circumstances • Dental care (adult/child), except in limited circumstances • Dental check-up • Experimental and/or investigational services	• Glasses • Hearing aids • Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S., except for urgent care • Orthotic and other corrective appliances for the foot • Services 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.)		
• Bariatric surgery, preauthorization required with limitations • Private Duty Nursing, preauthorization required 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: 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 SelectHealth Member Services, please call 800-538-5038 weekdays, TTY users should call 711, or visit us at selecthealth.org.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

The plan's overall deductible	$1,600
Specialist	Covered 100%
Hospital (facility)	Covered 100%
Other	Covered 100%

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

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,600
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%
Hospital (facility)	Covered 100%
Other	Covered 100%

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

Total Example Cost	$5,600

In this example, Joe would pay:

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

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	$2,800

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

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

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