



## SelectHealth Health Plans

Policy Number: G1006685

Base HMO Policy Number: L20A1983

\$1,000 Deductible Policy Number: L20A1984

### Eligibility

Employees and their dependents that are employed with Western AgCredit and live in the Utah area can elect the Health Maintenance Organization (HMO) medical coverage through SelectHealth Health Plans. Eligible dependents include the employee's lawful spouse and unmarried, financially dependent child(ren) up to age 26. Dependent child(ren) are defined as: natural, adopted, and/or children placed under legal guardianship through testamentary appointment or court order. Mentally or physically challenged child(ren) can be covered after the limiting age if they are dependent upon the employee for support and are not capable of self-sustaining employment. A dependent **does not** have to be full-time student. Financial dependency is defined as dependence upon the employee or the employee's lawful spouse for more than half of his or her support. Support includes food, shelter, clothing, education, medical and dental care, etc. Two options are available. You may select either the Base HMO or the \$1,000 deductible plan. An HMO is a group of doctors, hospitals, labs and other health care providers who work together. You may utilize the HMO if you live within the HMO service area. If you choose to participate in the HMO, you are required to see doctors and use hospitals that are members of the HMO.

Newly hired eligible employees who enroll within 30 days of their hire date will be covered on:

- a) The 16<sup>th</sup> of the month following date of hire if enrolled between the 1<sup>st</sup> and 15<sup>th</sup> of the month, or
- b) The 1<sup>st</sup> of the month following date of hire if enrolled between the 16<sup>th</sup> and the end of the month.

In the case of status changes made within 31 days of the event, the effective date will be the date of the status change.

Termination of Coverage – Coverage ends:

- a) On the 15<sup>th</sup> of the month if terminated between the 1<sup>st</sup> and 15<sup>th</sup> of the month; or
- b) The end of the month if terminated between the 16<sup>th</sup> and end of the month.

### Primary Care Physician

You do not need to choose a Primary Care Physician, but seeing one doctor routinely will establish a relationship that can improve your health care. You also do not need a referral from your Primary Care Physician (PCP) to see a specialist. See your Provider and Facility Directory for a list of participating plan providers.

**2008 Premium Rates**

*Below is the monthly premium for SelectHealth Base HMO and \$1,000 Deductible coverage:*

**Full-Time Employee (32+ Hours/week)**

	Base HMO			\$1,000 Deductible HMO		
	Employee	Employer	Total	Employee	Employer	Total
Employee Only	\$53	\$336	\$389	\$0	\$230	\$230
Employee+ Spouse	\$170	\$608	\$778	\$0	\$461	\$461
Employee+ Child(ren)	\$140	\$540	\$680	\$0	\$404	\$404
Family	\$286	\$881	\$1,167	\$0	\$689	\$689

**Part-Time Employee (20 – 31 Hours/week)**

	Base HMO			\$1,000 Deductible HMO		
	Employee	Employer	Total	Employee	Employer	Total
Employee Only	\$221	\$168	\$389	\$115	\$115	\$230
Employee+ Spouse	\$474	\$304	\$778	\$230.50	\$230.50	\$461
Employee+ Child(ren)	\$410	\$270	\$680	\$202	\$202	\$404
Family	\$726.50	\$440.50	\$1,167	\$344.50	\$344.50	\$689

**Vendor Contact Information**

Address	Telephone Numbers/Website
SelectHealth Member Services P.O. Box 30192 Salt Lake City, UT 84130	800-538-5038 <a href="http://www.selecthealth.org">www.selecthealth.org</a>

## SelectHealth Member Payment Summary

This is a summary of benefits and limitations. **THIS IS NOT A CONTRACT.** If you have a question about coverage, contact SelectHealth.

	<b>Base HMO</b>	<b>\$1,000 Deductible HMO</b>
<b>Conditions and Limits</b>		
Lifetime Maximum Plan Payment – Per person	\$2,500,000	\$2,500,000
Pre-existing Conditions	None	None
<b>Medical Deductible and Medical Out-of-Pocket Maximum</b>	<b>You Pay</b>	<b>You Pay</b>
Deductible – Per Person/family (per calendar year)	No Deductible	\$1,000/\$2,000
Out-of-Pocket maximum – Per Person/Family (per calendar year)	\$1,500/\$3,000	\$5,000/10,000 (Deductible Included)
<b>Inpatient Services</b>	<b>You Pay</b>	<b>You Pay</b>
Medical-Surgical, Hospice, Emergency Admit (semi-private room, board, anesthesia & all related services)	20%	20% after deductible
Maternity/Delivery	20%	20% after deductible
Skilled Nursing Facility - Up to 60 Days Per Year	20%	20% after deductible
Inpatient – Rehab Therapy: Physical, Speech, Occupational - Up to 40 Days Per Calendar Year for all therapy types combined	20%	20% after deductible
<b>Professional Services</b>	<b>You Pay</b>	<b>You Pay</b>
Office Visits & Minor Office Surgery – Primary Care Physician	\$15	\$15 after deductible
Office Visits & Minor Office Surgery – Secondary Care Physician	\$25	\$25 after deductible
Preventive Care – Includes routine exams, family planning, hearing and vision exams	All Ages, See Office Visits Above	All Ages, See Office Visits Above
Adult Immunizations	Covered 100%	Covered 100%
Pediatric Immunizations (for members age 17 and under)	Covered 100%	Covered 100%
Allergy Tests	All Ages, See Office Visits Above	All Ages, See Office Visits Above
Allergy Treatment and Serum	20%	20% after deductible
Major Office Surgery (Surgical and Endoscopic services over \$350)	20%	20% after deductible
Physician Fees – (Medical-Surgical, Maternity, Anesthesiologist)	20%	20% after deductible

	<b>Base HMO</b>	<b>\$1,000 Deductible HMO</b>
<b>Outpatient Services</b>	<b>You Pay</b>	<b>You Pay</b>
Outpatient Facility & Ambulatory Surgical – (all related services)	20%	20% after deductible
Ambulance Air – Emergencies Only	20%	20% after deductible
Ambulance Ground – Emergencies Only	20%	20% after deductible
Emergency Room – (participating facility) Includes all services rendered in conjunction with the ER	\$50	\$50 after deductible
Emergency Room – (non-participating facility) Includes all services rendered in conjunction with the ER	\$100	\$100 after deductible
Urgent Care Facility, Intermountain InstaCare	\$25	\$25 after deductible
Urgent Care Facility, Intermountain KidsCare	\$15	\$15 after deductible
Chemotherapy, Radiation & Dialysis	20%	20% after deductible
Diagnostic Tests: Minor	Covered 100%	Covered 100% after deductible
Diagnostic Tests: Major – including but not limited to: CT Scan, MRI/NMR, Neurological and Cardiovascular Diagnostics	20%	20% after deductible
Home Health, Hospice, Outpatient Private Nurse	20%	20% after deductible
Outpatient – Rehab Therapy: Physical, Speech, Occupational Up to 20 visits per calendar year for each therapy type	\$25	\$25 after deductible
<b>Miscellaneous Services</b>	<b>You Pay</b>	<b>You Pay</b>
Durable Medical Equipment (DME) – Inpatient or Outpatient	20%	20% after deductible
Miscellaneous Medical Supplies (MMS)	20%	20% after deductible
Infertility – Selected Services	*50% (Max Plan Payment: \$1,500/yr; \$5,000 lifetime)	*50% after deductible (Max Plan Payment: \$1,500/yr; \$5,000 lifetime)

\*Not applied to Medical out-of-pocket maximum

	<b>Base HMO</b>	<b>\$1,000 Deductible HMO</b>
<b>Benefit Riders</b>	<b>You Pay</b>	<b>You Pay</b>
Catastrophic Mental Health & Chemical Dependency (combined benefits)	To access your Mental Health benefits call: 1-800-876-1989	To access your Mental Health benefits call: 1-800-876-1989
Mental Health Deductible – Per Person/Family – (per calendar year)	No Deductible	\$1,000/\$2,000
Mental Health Out-of-Pocket Maximum – Per Person/Family – (per calendar year)	\$1,500/\$3,000	\$5,000/\$10,000
Mental Health Office Visits	\$15	\$15 after mental health deductible
Inpatient	50%	50% after mental health deductible
Outpatient	50%	50% after mental health deductible
Injectable Drugs	20% with Prior Authorization	20% after deductible with Prior Authorization
Preferred Prescription Drugs – Up to 30 Day Supply of Covered Medications	*\$5 generic/*\$20 name brand preferred drugs *\$40 for non-preferred drugs	*\$5 generic/*\$20 name brand preferred drugs *\$40 for non-preferred drugs
90 Day Maintenance Mail Order Benefit – selected drugs	*\$5 generic/*\$40 name brand preferred drugs *\$120 for non-preferred drugs	*\$5 generic/*\$40 name brand preferred drugs *\$120 for non-preferred drugs
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic	Generic required or must pay copay plus cost difference between name brand and generic
Supplemental Accident – deductible, copay & coinsurance apply thereafter (per person per calendar year within 1 year of accident)	Not applicable	Covered 100% for 1 <sup>st</sup> \$1,000

\*Not applied to Medical out-of-pocket maximum

All copayments/coinsurance amount and plan payments are based on eligible charges only and not on the provider's billed or other charges. You are responsible to pay for excess charges in excess of eligible charges for covered services obtained from non-participating providers and facilities. Such excess charges are not applied to the medical out-of-pocket maximum. Refer to your contract, membership guide, or provider and facility directory for more information.

[This information is deemed to be accurate. In the event that this information is in conflict with the vendor contract or the policy, the contract or policy language will prevail. The employers intend to provide these programs on an ongoing basis; however, they reserve the right to amend or terminate any program at any time.]