Weber County

proposal - option 2

Proposal Assumptions
Medical Rates and Payment Summaries

Select Health

BH/KP

This proposal is made on the basis of information provided to Select Health and is subject to the above criteria as well as properly completed group and membership applications. Applications are to be submitted to and approved by Select Health Underwriting before the proposed effective date. Otherwise, Select Health may choose to delay the effective date.

This proposal assumes benefits are paid according to the Group Health Insurance contract and standard operating procedures of Select Health. No deviations or exceptions are expected. Any exception must be approved prior to the group's effective date.

MINIMUM PARTICIPATION AND CONTRIBUTION REQUIREMENTS

Failure to comply with any of the following requirements may result in corrective underwriting actions according to the terms outlined in the master group contract.

- Employer contributions must be at least 90% of the employee cost or 50% across all tiers.
- 75% of eligible employees must participate in an employer sponsored health plan.
- Employer may not incentivize employees to not elect coverage.
- The number of out-of-area participants may not exceed 40% of the group's enrolled employees.

UNDERWRITING ASSUMPTION REQUIREMENTS

- Active Employees: 717
- If enrollment differs by more than 15% during the contract year, Select Health reserves the right to reevaluate rates and plan designs.
- Confirmation and notification of renewal plan and rates must be received by Select Health by the first day of the month prior to renewal. If confirmation is not received by the first day of the prior month, Select Health will automatically assume Option 1 was selected.

EMPLOYEE ELIGIBILITY REQUIREMENT

- Eligible employees include permanent full-time personnel (hourly and salaried) who reside within the plan's service area(s).
- Covered dependents will not be removed from the subscriber's policy for any reason other than reaching age 26, or upon the request of the subscriber. Coverage will be terminated at the end of the month in which the dependent child turns 26.

Select Health

Medical Plan Option 2

EFFECTIVE 01/01/26 THROUGH 12/31/26

	Med Network Traditional Current	Tier Network Traditional Proposed
Employee	$884.80	$909.50
Two-Party	$2,082.40	$2,140.60
Family	$2,522.10	$2,592.50

	Med Network HSA Qualified Current	Tier Network HSA Qualified Proposed
Employee	$745.60	$766.40
Two-Party	$1,754.50	$1,803.50
Family	$2,125.00	$2,184.40

	Value Network Traditional Current	Tier Network Traditional Proposed
Employee	$819.40	$909.50
Two-Party	$1,929.50	$2,140.60
Family	$2,337.70	$2,592.50

	Value Network HSA Qualified Current	Tier Network HSA Qualified Proposed
Employee	$686.70	$766.40
Two-Party	$1,616.00	$1,803.50
Family	$1,958.10	$2,184.40

Overall Renewal Increase 6.9%

1. We may reasonably modify the premium if federal or state laws or regulations mandate that we adjust benefits under the Contract.
2. This proposal (and associated premium rates) has been calculated based on the following commission/service fee arrangement as proposed by the submitting agent: Net of Commission.
3. An additional fee of $2.00 pepm will be billed when an HSA Qualified plan is paired with a HealthEquity HSA.
4. Please provide a client signature on the sold rate sheet and initial the correlating Member Payment Summaries. Note: Member materials will not be generated until rates, plan designs and commissions are confirmed.

Client Signature_____ Date _____

Select Health

VALUE AND MED NETWORKS

	MEMBER PAYMENT SUMMARY		
	TIER 1 VALUE When using In-Network Providers, you are responsible to pay the amounts in this column. These providers might not be available in all areas	**TIER 2 MED** When using In-Network Providers, you are responsible to pay the amounts in this column.	**OUT-OF-NETWORK** When using Out-of-Network Providers, you are responsible to pay the amounts in this column.
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Self Only Coverage, 1 person enrolled - per calendar Year			
Deductible	$1,500		$4,000
Out-of-Pocket Maximum	$5,000		$10,000
Family Coverage, 2 or more enrolled - per calendar Year			
Deductible - per person/family	$1,500/$3,000		$4,000/$8,000
Out-of-Pocket Maximum - per person/family	$5,000/$10,000		$10,000/$20,000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)			
INPATIENT SERVICES	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Medical, Surgical and Hospice[4]	20% after Deductible	20% after Deductible	40% after Deductible
Hospital Level Care at Home[4]	20% after Deductible	20% after Deductible	Not Covered
Skilled Nursing Facility[4] - Up to 60 days per calendar Year	20% after Deductible	20% after Deductible	40% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4] Up to 40 days per calendar Year for all therapy types combined	20% after Deductible	20% after Deductible	40% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible	20% after Deductible	40% after Deductible
PROFESSIONAL SERVICES	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Office Visits & Minor Office Surgeries			
Primary Care Provider (PCP)[1]	$40	$40	40% after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100%	Covered 100%	Not Covered
Specialist/Secondary Care Provider (SCP)[1]	$60	$60	40% after Deductible
Allergy Tests	See Office Visits Above	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20%	20%	Not Covered
Major Surgery	20%	20%	40% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible	20% after Deductible	40% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Primary Care Provider (PCP)[1]	Covered 100%	Covered 100%	Not Covered
Specialist/Secondary Care Provider (SCP)[1]	Covered 100%	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Covered 100%	Not Covered
VISION SERVICES	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Preventive Eye Exams	Covered 100%	Covered 100%	Not Covered
All Other Eye Exams	$60	$60	40% after Deductible
OUTPATIENT SERVICES[4]	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Outpatient Facility	20% after Deductible	20% after Deductible	40% after Deductible
Ambulatory Surgical Center	10% after Deductible	10% after Deductible	40% after Deductible
Imaging Center	10% after Deductible	10% after Deductible	40% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after Deductible	See In-Network Benefit	See In-Network Benefit
Emergency Room	$500 after Deductible	See In-Network Benefit	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$60	$60	40% after Deductible
Intermountain KidsCare® Facilities	$40	$40	Not Available
Intermountain Connect Care®	Covered 100%	Covered 100%	Not Available
Radiation	20% after Deductible	20% after Deductible	40% after Deductible
Dialysis	20% after Deductible	20% after Deductible	40% after Deductible
Diagnostic Tests: Minor[2]	Covered 100%	Covered 100%	40% after Deductible
Diagnostic Tests: Major[2]	20% after Deductible	20% after Deductible	40% after Deductible
Home Health, Hospice, Outpatient Private Nurse	20% after Deductible	20% after Deductible	40% after Deductible
Outpatient Cardiac Rehab	Covered 100%	Covered 100%	40% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$60 after Deductible	$60 after Deductible	40% after Deductible

See other side for additional benefits

Select Health

VALUE AND MED NETWORKS

	MEMBER PAYMENT SUMMARY		
	TIER 1 VALUE	**TIER 2 MED**	**OUT-OF-NETWORK**
MISCELLANEOUS SERVICES	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment (DME)[4]	20% after Deductible	20% after Deductible	40% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after Deductible	20% after Deductible	40% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Substance Use Disorder Services	See Professional, Inpatient, Outpatient, or Mental Health and Substance Use Disorder Services	See Professional, Inpatient, Outpatient, or Mental Health and Substance Use Disorder Services
Maternity and Adoption[4,7]	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	40% after Deductible
Cochlear Implants or Auditory Osseointegrated Devices[2,4] *One device every 36 months per ear*	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services*	50% after Deductible	50% after Deductible	Not Covered
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	Not Covered
OPTIONAL BENEFITS	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Mental Health and Substance Use Disorder[4]			
Office Visits	$40	$40	40% after Deductible
Virtual Visits	Covered 100%	Covered 100%	40% after Deductible
Inpatient	20% after Deductible	20% after Deductible	40% after Deductible
Outpatient	20%	20%	40% after Deductible
Residential Treatment[2]	20% after Deductible	20% after Deductible	40% after Deductible
Chiropractic *(up to 20 visits per calendar Year)*	$40	$40	Not Covered
Healthcare Provider Administered Injectable or Infusible Drugs[4]	20% after Deductible	20% after Deductible	40% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	Not Covered
PRESCRIPTION DRUGS			
Pharmacy Deductible - Per Person per calendar Year	$200		
Prescription Drug List (formulary)	RxSelect®		
Prescription Drugs - *Up to 30 Day Supply of Covered Medications*[4]			
Tier 1	$20		
Tier 2	$45 after pharmacy Deductible		
Tier 3	$65 after pharmacy Deductible		
Tier 4	$100 after pharmacy Deductible		
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90®)-selected drugs*[4]			
Tier 1	$20		
Tier 2	$90 after pharmacy Deductible		
Tier 3	$195 after pharmacy Deductible		
Generic Substitution Required	Generic required or must pay Copay plus cost difference between name brand and generic		

1 Refer to **selecthealth.org/find-care** to identify whether a Provider is a primary or secondary care Provider.

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some Preventive care and MMS Services.

4 Preauthorization is required for certain Services. Benefits may be reduced or denied if you do not preauthorize certain Services with Out-of-Network Providers. Please refer to Section 11--" Healthcare Management", in your Certificate of Coverage, for details.

5 All Deductible/Copay/Coinsurance amounts are based on the Allowed Amount and not on billed charges. Out-of-Network Providers or Facilities may not accept the Allowed Amount for Covered Services. When this occurs, you may be responsible for Excess Charges.

6 Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.

7 Select Health provides a $4000 adoption indemnity as outlined by the state of Utah. Medical Deductible, Copay, or Coinsurance listed under the benefit applies and may exhaust the benefits prior to any plan payments.

* Not applied to Medical Out-of-Pocket Maximum.

Select Health will cover an insulin from each therapeutic category with a cap of $10 per prescription of a 30-day supply.

All Covered Services obtained outside the United States, except for routine, Urgent, or Emergency conditions require preauthorization.

To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.

Select Health

VALUE AND MED NETWORKS / HSA QUALIFIED

	MEMBER PAYMENT SUMMARY		
	TIER 1 VALUE When using In-Network Providers, you are responsible to pay the amounts in this column. These providers might not be available in all areas.	**TIER 2 MED** When using In-Network Providers, you are responsible to pay the amounts in this column.	**OUT-OF-NETWORK** When using Out-of-Network Providers, you are responsible to pay the amounts in this column.
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Self Only Coverage, 1 person enrolled - per calendar Year			
Deductible	$3,500		$3,750
Out-of-Pocket Maximum	$3,500		$5,000
Family Coverage, 2 or more enrolled - per calendar Year			
Deductible	$7,000		$7,500
Out-of-Pocket Maximum	$7,000		$10,000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)			
INPATIENT SERVICES	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Medical, Surgical and Hospice[4]	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Hospital Level Care at Home[4]	Covered 100% after Deductible	Covered 100% after Deductible	Not Covered
Skilled Nursing Facility[4] - Up to 60 days per calendar Year	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Up to 40 days per calendar Year for all therapy types combined			
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
PROFESSIONAL SERVICES	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Office Visits & Minor Office Surgeries			
Primary Care Provider (PCP)[1]	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100% after Deductible	Covered 100% after Deductible	Not Covered
Specialist/Secondary Care Provider (SCP)[1]	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Allergy Tests	See Office Visits Above	See Office Visits Above	Not Covered
Allergy Treatment and Serum	Covered 100% after Deductible	Covered 100% after Deductible	Not Covered
Major Surgery	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
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Ambulatory Surgical Center	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Imaging Center	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	Covered 100% after Deductible	See In-Network Benefit	See In-Network Benefit
Emergency Room	Covered 100% after Deductible	See In-Network Benefit	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Intermountain KidsCare® Facilities	Covered 100% after Deductible	Covered 100% after Deductible	Not Available
Intermountain Connect Care®	Covered 100% after Deductible	Covered 100% after Deductible	Not Available
Radiation	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Dialysis	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Diagnostic Tests: Minor[2]	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Diagnostic Tests: Major[2]	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Home Health, Hospice, Outpatient Private Nurse	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Outpatient Cardiac Rehab	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible

See other side for additional benefits

Select Health

VALUE AND MED NETWORKS / HSA QUALIFIED

	MEMBER PAYMENT SUMMARY		
	TIER 1 VALUE	**TIER 2 MED**	**OUT-OF-NETWORK**
MISCELLANEOUS SERVICES	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment (DME)[4]	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Substance Use Disorder Services	See Professional, Inpatient, Outpatient, or Mental Health and Substance Use Disorder Services	See Professional, Inpatient, Outpatient, or Mental Health and Substance Use Disorder Services
Maternity and Adoption[4,7]	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	40% after Deductible
Cochlear Implants or Auditory Osseointegrated Devices[2,4] *One device every 36 months per ear*	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services*	Covered 100% after Deductible	Covered 100% after Deductible	Not Covered
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	Not Covered
OPTIONAL BENEFITS	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Mental Health and Substance Use Disorder[4]			
Office Visits	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
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Chiropractic *(up to 20 visits per calendar Year)*	Covered 100% after Deductible	Covered 100% after Deductible	Not Covered
Healthcare Provider Administered Injectable or Infusible Drugs[4]	Covered 100% after Deductible	Covered 100% after Deductible	40% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	Not Covered
PRESCRIPTION DRUGS			
Prescription Drug List (formulary)	RxSelect®		
Prescription Drugs-*Up to 30 Day Supply of Covered Medications*[4]			
Tier 1	Covered 100% after In-Network Deductible		
Tier 2	Covered 100% after In-Network Deductible		
Tier 3	Covered 100% after In-Network Deductible		
Tier 4	Covered 100% after In-Network Deductible		
Maintenance Drugs-*90 Day Supply (Mail-Order, Retail90®)-selected drugs*[4]			
Tier 1	Covered 100% after In-Network Deductible		
Tier 2	Covered 100% after In-Network Deductible		
Tier 3	Covered 100% after In-Network Deductible		
Generic Substitution Required	Generic required or must pay Copay plus cost difference between name brand and generic		

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