Select Health Group MSA Summary of Benefits.

ALL STATES | 2026

The Summary of Benefits is meant to help you understand what we cover and what you pay. It doesn't list every service we cover or every limitation or exclusion. To get a complete list of services we cover, view the Evidence of Coverage document at **selecthealthgroupmsa.org**.

What is an MSA?

An MSA, or Medical Savings Account, is a Medicare Advantage plan that pairs high-deductible medical benefits coverage with a special, IRS-approved bank account. You receive an annual deposit of money into your MSA bank account that you decide how to spend, save or invest for your health care needs.

The plan covers all Medicare Parts A and B services. Below the deductible, you are responsible for paying all covered costs, including preventive care costs. Once you reach the deductible, the plan is responsible for paying all covered costs. You can apply the deposit funds toward under-deductible costs.

Who can join Select Health Group MSA?

To join an MSA, you must be enrolled in Medicare Part A and Part B and meet the additional requirements shown on page 4.

Which doctors and hospitals can I use?

By law, MSAs cannot restrict members to a network. Instead, you have access to any Medicare-participating provider in the U.S. who is willing to bill the plan. Medicare allows its participating providers to decide at each visit whether or not to accept the MSA. The good news? Most providers accept the MSA. And, you cannot be denied service due to your insurance in an emergency.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or get a copy by calling 1-800-MEDICARE (**1-800-633-4227**), 7 days a week, 24 hours a day. TTY users should call **1-877-486-2048**.

HOW TO CONTACT US

Call us toll-free at **855-511-1514 (TTY: 711)** or visit **selecthealthgroupmsa.org**

Hours of operation:

Monday through Friday
7:00 a.m. to 4:00 p.m. Mountain time, excluding federal holidays and the day after Thanksgiving.

Outside of these hours of operation, please leave a message and your call will be returned within one business day.

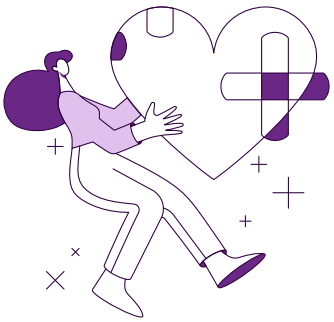
Select Health
powered by Fenyx Health

Select Health Group Medical Savings Account (MSA)

Self Employed H6130_811, Self Employed Plus H6130_815, Self Employed Growth H6130_816, Self Employed Max H6130_818
All counties in all 50 United States plus the District of Columbia:

BENEFIT	SELF EMPLOYED PLANS: BASE PLAN COST	PLUS PLAN COST	GROWTH PLAN COST	MAX PLAN COST
Medical Premium, Deductible, Deposit and Limits[1]				
Premium Amount	$0	$0	$0	$0
Deductible	$5,000	$8,400	$12,000	$16,000
Deposit ($2,400 annual plus monthly amount shown in [ ] when received from group/employer)	$4,800 [$200]	$8,400 [$500]	$12,000 [$800]	$24,000 [$1,800]
Equivalent Out-of-Pocket Maximum Deductible minus deposit	$200	$0	$0	($8,000)
Medical Benefits				
Inpatient Hospital Coverage Days 1-90 per benefit year and up to 60 lifetime reserve days	Our plans cover the same Part A and Part B services and items (collectively, "services") as Original Medicare. There are no additional or supplemental services covered by the plans. Our plans use the same medical policy, claims processing and pricing rules as Medicare. Until you meet your yearly deductible, you pay the lesser of a) the billed amount or b) 100% of the Medicare-allowed amount for covered services obtained from Medicare-participating providers. For covered services obtained from Medicare non-participating providers, you pay the lesser of a) the billed amount or b) 95% of the Medicare-allowed amount. After you meet your deductible, you pay $0 for covered services obtained from Medicare providers. Some services may require a prior authorization or physician referral, as Medicare requires them. Our plans do not have any additional requirements. Your provider may recommend services in excess of what Medicare covers. Or, they may recommend services that Medicare doesn't cover. If this happens, you may have to pay some or all of the costs. You are always responsible for paying the full costs of a) non-covered services, b) any services obtained from providers opting out of Medicare and c) excess charges from providers not participating in and accepting of Medicare rates.			
Outpatient Hospital Coverage				
Ambulatory Surgical Center Services				
Doctor's Office Visits				
Preventive Care Annual physical/comprehensive wellness visit Medicare-covered preventive services				
Emergency Care				
Urgently Needed Services				
Diagnostic Services, Labs, and Imaging Diagnostic tests and procedures Lab services Outpatient x-rays Diagnostic colonoscopy Diagnostic radiology services (e.g., MRIs, CT scans) Therapeutic radiology services				
Hearing Services Hearing and balance exams when ordered by your provider to find out if you need treatment One audiologist visit once every 12 months without an order for non-acute hearing conditions Diagnostic services related to hearing loss that's treated with surgically implanted hearing devices Routine hearing services, hearing aid fittings and hearing aids not covered				

Dental Services Dental services received when admitted as a hospital inpatient for your dental procedure, either because of your underlying medical condition or the severity of the procedure Specific inpatient or outpatient dental services directly related to certain covered medical treatments Routine dental services not covered	
Vision Services Outpatient physician services for the diagnosis and treatment of eye diseases and injuries One glaucoma screening every 12 months if you are considered high-risk One diabetic retinopathy exam every 12 months if you have diabetes One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens Routine eye exams (also called refraction exam) for eyeglasses and contact lenses not covered	Our plans cover the same Part A and Part B services and items (collectively, "services") as Original Medicare. There are no additional or supplemental services covered by the plans. Our plans use the same medical policy, claims processing and pricing rules as Medicare. Until you meet your yearly deductible, you pay the lesser of a) the billed amount or b) 100% of the Medicare-allowed amount for covered services obtained from Medicare-participating providers. For covered services obtained from Medicare non-participating providers, you pay the lesser of a) the billed amount or b) 95% of the Medicare-allowed amount. After you meet your deductible, you pay $0 for covered services obtained from Medicare providers. Some services may require a prior authorization or physician referral, as Medicare requires them. Our plans do not have any additional requirements. Your provider may recommend services in excess of what Medicare covers. Or, they may recommend services that Medicare doesn't cover. If this happens, you may have to pay some or all of the costs. You are always responsible for paying the full costs of a) non-covered services, b) any services obtained from providers opting out of Medicare and c) excess charges from providers not participating in and accepting of Medicare rates.
Inpatient Mental Health Services At a general hospital: Days 1-90 per benefit year and up to 60 lifetime reserve days At a freestanding psychiatric hospital: Up to 190 lifetime reserve days	
Outpatient Mental Health Services Individual therapy Group therapy Partial hospitalization	
Skilled Nursing Facility (SNF) Days 1-100 per benefit year, with a prior, qualifying inpatient hospital stay	
Outpatient Physical Therapy Physical therapy Occupational therapy Speech-language therapy	
Ambulance and Transportation Emergent ground or air ambulance Non-emergent transportation with a provider's order	
Medicare Part B Drugs Chemotherapy, insulin and other Part B drugs and biologics; usually administered at provider's office or at home using specialized equipment	



Joining our MSA.

Medicare has special requirements to enroll in an MSA plan.

We Make Enrolling in Our MSAs Easy

Eligibility Requirements

To join (enroll in) our plans, you must:

- Be Medicare-eligible and enrolled in both Medicare Parts A and B
- Be an eligible beneficiary of the group offering the MSA plans
- Reside in the U.S. for 183 days or more during the calendar year
- Not receive Medicare hospice benefits
- Not be eligible for Medicaid (not be dual-eligible)
- Not have other medical coverage that covers the MSA plan deductible, such as TRICARE, Veteran's Affairs (VA), Federal Employee Health Benefit Plan (FEHBP) or major medical benefits under an employer or union group
- Live in our service area (50 states plus D.C.)

Medical Benefits and Banking Account Setup

Enrollment in the Select Health Group MSA plans includes both 1) establishment of the MSA bank account and 2) enrollment in the medical benefits plan. Your enrollment is not complete until both components are successfully established.

We use multiple banking partners to administer MSA bank accounts. Your banking materials will be sent upon enrollment in the plan; upon receipt, if you do not agree to the bank terms, conditions and agreements, please contact us as soon as possible to disenroll from the plan.

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. **What this means for you: When you open an account, we will ask for your name, address, date of birth and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents. You will need to provide your Social Security Number (SSN) as part of the enrollment request.**

The Basics of an MSA

You decide how to use the deposit funds for your health care. Funds can be used on any expense, with varied deductible and tax implications.

You pay less out-of-pocket to reach the plan deductible if you apply the deposit funds toward plan-covered expenses.

The plan is not financially responsible for covered services, including preventive services, until you reach your deductible.

Unspent funds at the end of the year belong to you and roll over to the following year, potentially growing your funds over time.

Some of our banking partners allow you to invest balances over a certain amount, another way you can potentially grow funds over time.

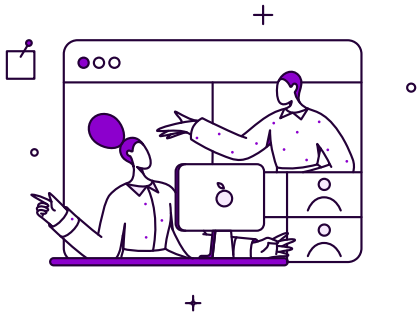
By law, MSAs cannot include prescription drug (Part D) coverage, so you can and should enroll in a separate Part D plan best fitting your needs.

MSAs cannot, by law, limit you to a network. You have access to any Medicare provider across the U.S. who agrees to treat you/bill the plan. Medicare allows its providers to decide at each visit whether or not to accept the MSA.

MSA funds are not taxed at the time of deposit, while accruing in your bank account or when spent on IRS-deemed Qualified Medical Expenses.

If using MSA funds during the year, for any reason, you will need to file a tax return including IRS Forms 8853 and 1040.

Membership is calendar year based. The deposit and deductible are prorated for partial-year enrollments. You owe a prorated portion of the current year's deposit back to Medicare if you leave the plan, for any reason, before 12/31.



Know and grow.

Knowing how the plan components work together is key to maximizing your MSA's value.

The Three Major Components of the MSA Plan

The Deductible

- ***Deductible:*** the total amount a member must pay for covered services before the insurance plan starts to pay.
- Many types of insurance plans have deductibles, so deductibles are not unique to MSAs.
- In an MSA, the deductible is the maximum amount a member will pay for covered services.

The Deposit

- ***Deposit:*** the money placed into a member's MSA bank account.
- The deposit is usually initiated in the first five days of your effective, or start, date. Posting depends on the banking partner's schedule, but the funds are usually available in the second week. You do not have to wait for the funds to be placed before obtaining care as a plan member.
- Members receive an additional monthly deposit each month their group/employer contributes the required funds.
- MSAs are the only Medicare Advantage plan that provide a deposit.
- The deposit is intended to be applied toward the plan deductible, but you choose what to do with the funds.

The Equivalent Maximum Out-of-pocket

- ***Equivalent maximum out-of-pocket***: the minimum amount of out-of-pocket funds needed to reach the plan deductible. We sometimes call this the covered services out-of-pocket or the difference. It's a simple equation: the deductible minus the deposit.
- Many plans require out-of-pocket costs such as premiums, deductibles, copays, coinsurance and more.
- You pay less out-of-pocket when you apply your deposit toward covered expenses.

Spending MSA Funds: Deductible and Tax Implications

You choose how to spend, save or invest your deposit, with varying impacts to the deductible and taxes.

	Covered Expenses (Medicare A / B)	Qualified Medical Expenses Outside of Medicare A / B	Non-medical Expenses
Examples	• Inpatient hospital care • Skilled nursing facility care • Preventive services • Doctor office visits • Lab tests • Imaging • Home health care • Durable medical equipment	• Routine dental care • Eye refraction exams • Hearing aids • Deductibles, copays and coinsurance for ancillary plans like prescription drug, dental, vision, etc. • Premiums, deductibles, copays and coinsurance for long-term care	• Premiums for ancillary plans like prescription drug, dental, vision, etc. • Food and groceries • Rent or home payments • Clothing • Entertainment • Medical expenses for a spouse or other person
Expense counts toward deductible?	✓ when incurred from Medicare providers	✗	✗
Pay with MSA funds?	✓	✓	✓
Use MSA funds tax and penalty-free?	✓	✓	✗

Please see IRS Publications 8853, 969 and 502 for more information on tax implications.

Our Financial Support Program Benefits You and Your Providers

Additional financial flexibility for you, and your providers receive timely and in-full payment from us.

Have your provider send the claim to us.

We determine medical necessity, pricing and payment responsibility.

Payment responsibility results in one of these scenarios:

Expense is plan-covered and you are under your deductible:
We pay the provider on your behalf, then bill you.

Expense is plan-covered and you are over your deductible:
We pay the provider.

Expense is not plan-covered, regardless of deductible:
The provider bills you and you pay the provider.

Select Health Group MSA is an MSA plan with a Medicare contract held and administered by Fenyx Health Insurance Company. Enrollment in the Plan depends on contract renewal.

Select Health Group MSA obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status. This information is available for free in other languages and alternate formats.

Select Health Group MSA: **1-855-511-1514** (TTY: 711)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電.

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