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. Please read the FEHB Plan brochure (RI 73-865) that contains the complete terms of this plan. All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure. Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.selecthealth.org/fehb, and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 1-844-345-FEHB to request a copy of either document.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$ 0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$ 5,000/Self Only $10,000/Self Plus One $10,000/Self and Family</td>
<td>The out-of-pocket limit, or catastrophic maximum, 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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, Infertility, Bariatric Surgery, Chiropractic and health care this Plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.selecthealth.org/fehb.com">www.selecthealth.org/fehb.com</a> or call 1-844-345-FEHB for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| If you visit a health care provider's office or clinic                  | Primary care visit to treat an injury or illness | Network Provider (You will pay the least): $15/visit  
Non-Participating Provider (You will pay the most, plus you may be balance billed): Not covered |
|                                                                        | Specialist visit                             | $25/visit  
Not covered |
|                                                                        | Preventive care/screening/immunization       | No charge  
Not covered |
| If you have a test                                                      | Diagnostic test (x-ray, blood work)          | No charge  
Not covered |
|                                                                        | Imaging (CT/PET scans, MRIs)                 | 10% coinsurance  
Not covered |
| If you need drugs to treat your illness or condition                    | Generic drugs                                | Retail: $5/prescription  
Mail Order: $5/prescription  
Not covered  
Certain limitations apply.  
30-day supply (retail)  
90-day supply (mail) |
| If you need drugs to treat your illness or condition                    | Preferred brand drugs                         | Retail: $25/prescription  
Mail Order: $50/prescription  
Not covered |
| If you need drugs to treat your illness or condition                    | Non-preferred brand drugs                     | Retail: $50 coinsurance  
Mail Order: 50% coinsurance  
Not covered |
| If you need drugs to treat your illness or condition                    | Specialty drugs                               | 30% coinsurance  
Not covered |
| If you have outpatient surgery                                          | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance  
Not covered  
Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services. |
| If you have outpatient surgery                                          | Physician/surgeon fees                        | 10% coinsurance  
Not covered  
Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services. |
| If you need immediate medical attention                                 | Emergency room care                           | $175/visit  
$175/visit  
Emergencies only. |
|                                                                        | Emergency medical transportation              | 10% coinsurance  
10% coinsurance  
Emergencies only. |

For more information about limitations and exceptions, see the FEHB Plan brochure RI 73-865 at www.selecthealth.org/fehb.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent care</strong></td>
<td></td>
<td></td>
<td>Applies to urgent care facilities only.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$25/visit</td>
<td>$25/visit</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$15/visit 10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$250/admission</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$200/admission</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$25/visit for office/outpatient 10% coinsurance for inpatient</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$25/visit for office/outpatient 10% coinsurance for inpatient</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Non-Participating Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most, plus you may be balance billed)</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>$250/admission</td>
<td>Not covered</td>
<td>Up to 60 days per calendar year. Benefits may be reduced or denied by 50% for failure to obtain a preauthorization for certain services.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>Not covered</td>
<td>Benefits may be reduced or denied by 50% for failure to obtain a preauthorization for certain services.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>$250/admission</td>
<td>Not covered</td>
<td>Benefits may be reduced or denied by 50% for failure to obtain a preauthorization for certain services.</td>
</tr>
</tbody>
</table>

If your child needs dental or eye care:
- Children’s eye exam: $25/visit Not covered None
- Children’s glasses: Not covered Not covered
- Children’s dental check-up: Not covered Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan’s FEHB brochure for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility Treatment
- Long-term care
- Orthognathic services
- Services that are not medically necessary

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan’s FEHB brochure.)

- Bariatric surgery
- Chiropractic care
- Hearing Aids
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-844-345-FEHB or visit www.opm.gov.insure/health. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or

For more information about limitations and exceptions, see the FEHB Plan brochure RI 73-865 at www.selecthealth.org/fehb.
receive temporary continuation of coverage (TCC). 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: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, “How you get care,” and Section 8 “The disputed claims process,” in your plan’s FEHB brochure. If you need assistance, you can contact the SelectHealth Appeals department at 1-844-208-9012.

Does this plan provide Minimum Essential Coverage? Yes
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

Language Access Services:
In order to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, a plan or issuer follows the rules in the claims and appeals regulations under PHS Act section 2719. Plans and issuers can find written translations of the SBC template and uniform glossary in non-English languages at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: N/A
- Specialist copayment: $25
- Hospital (facility) coinsurance: $250
- Other coinsurance: 10%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$200</td>
</tr>
</tbody>
</table>

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

- The plan’s overall deductible: $0
- Specialist copayment: $25
- Hospital (facility) coinsurance: $250
- Other coinsurance: 10%

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

Total Example Cost: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$80</td>
</tr>
<tr>
<td>The total Joe would pay is</td>
<td>$480</td>
</tr>
</tbody>
</table>

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

- The plan’s overall deductible: $0
- Specialist copayment: $25
- Hospital (facility) coinsurance: $250
- Other coinsurance: 10%

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: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$175</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$20</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$80</td>
</tr>
<tr>
<td>The total Mia would pay is</td>
<td>$195</td>
</tr>
</tbody>
</table>

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.

The plan would be responsible for the other costs of these EXAMPLE covered services.
Non-Discrimination Notice

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

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

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

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Language Access Services

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

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

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

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth: 800-538-5038.

Navajo
Díí baa akó nínízin: Díí saad bee yániltí’go Diné Bizaad, saad bee ák’ànida’ awo’dé’ę”, t’áá jìik’eh, éi ná hóól, kojí’ hóódlíih SelectHealth: 800-538-5038.

Nepali
ध्वनि दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निर्धारित भाषा सहयोग निःशुल्क रूपमा उपलब्ध छ। SelectHealth: 800-538-5038 मा फोन गर्नुहोस्।

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

Arabic
ٌناء عَمَلَت: نَكَذب 如果 عَمَلَت تَنْتَبِهِ تَنَكَذَلا: تَطْوَحُم فَكْرُبِلْص أَضْنَا تَاجَلَاب كُلَ رَفْعُتُ كَوْعَغُلا SelectHealth: 800-538-5038.

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

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

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