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. You can get the FEHB Plan brochure at **selecthealth.org/fehb** or by calling **800-538-5038**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $4,000/Self Only/ Self Plus One/Self and Family	The **out-of-pocket limit,** or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses. The "per covered individual" amount is the most that any one member would have to pay, regardless of whether the individual is enrolled in Self Plus One, or Self and Family.
What is not included in the out–of–pocket limit?	Premiums, infertility, chiropractic, bariatric surgery, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Visit **selecthealth.org/fehb** to find a provider or call **800-538-5038**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. [We use the terms **preferred** or participating for **providers** in our **network**.] See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See this plan's FEHB brochure for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use A		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit	Not covered	----------None----------
	Specialist visit	$25/visit	Not covered	
	Other practitioner office visit	$20/visit for chiropractic	Not covered	Chiropractic, up to 20 visits per calendar year. In Utah, administered by American Specialty Health Network, 800-678-9133. In Idaho, use BrightPath providers. Acupuncture is not covered.
	Preventive care/screening/immunization	No charge	Not covered	Frequency limitations apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	----------None----------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use A		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **selecthealth.org/fehb**.	Generic drugs	Retail: $5/prescription Mail Order: $5/prescription	Not covered	Certain limitations apply. Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services.
	Preferred brand drugs	Retail: $25/prescription Mail Order: $50/prescription	Not covered	
	Non-preferred brand drugs	Retail: $50/prescription Mail Order: 50% coinsurance	Not covered	
	Specialty drugs	20% coinsurance	Not covered	Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	----------None----------
	Physician/surgeon fees	10% coinsurance	Not covered	
If you need immediate medical attention	Emergency room services	$75/visit	$75/visit	Emergency room services apply to participating services.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Emergencies only.
	Urgent care	$25/visit	$25/visit	Applies to urgent care facilities only.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100/admit	Not covered	Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services.
	Physician/surgeon fee	10% coinsurance	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use A		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15/visit for office visits or 10% coinsurance for outpatient	Not covered	----------None----------
	Mental/Behavioral health inpatient services	$100/admit	Not covered	Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services.
	Substance use disorder outpatient services	$15/visit for office visits or 10% coinsurance for outpatient	Not covered	----------None----------
	Substance use disorder inpatient services	$100/admit	Not covered	Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	----------None----------
	Delivery and all inpatient services	$100/admit	Not covered	Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services.

Common Medical Event	Services You May Need	Your Cost If You Use A		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services.
	Rehabilitation services	$25/visit for outpatient and $100/admit for inpatient	Not covered	Up to 60 visits/calendar year for each therapy type for outpatient physical, occupational, and speech therapy. Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services.
	Habilitation services	$25/visit for outpatient and $100/admit for inpatient	Not covered	
	Skilled nursing care	$100/admit	Not covered	Up to 60 days/calendar year. Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services.
	Durable Medical Equipment (DME)	10% coinsurance	Not covered	For certain DME, benefits may be reduced or denied by 50% for failure to obtain preauthorization.
	Hospice service	$100/admit 10% coinsurance	Not covered	Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services.
If your child needs dental or eye care	Eye exam	$25/visit	Not covered	----------None----------
	Glasses	Not covered	Not covered	Glasses are not covered.
	Dental check-up	Not covered	Not covered	Dental check-ups are not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check this plan's FEHB brochure for other excluded services.)

- Abortions/terminations of pregnancy, except in limited circumstances
- Acupuncture
- Administrative services
- Attention-Deficit/Hyperactivity Disorder
- Autism spectrum disorder services greater than $30,000 or $600 hours, whichever is greater
- Complications for a non-covered service
- Cosmetic surgery/services and reconstructive and corrective services, except in limited circumstances
- Dental care (adult/child), except in limited circumstances
- Dental check-ups
- Experimental and/or investigational services
- Glasses
- Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid, and Yellow Fever
- Long-term care
- Non-emergency care when traveling outside the U.S., except for urgent care
- Orthognathic services
- Orthotics and other corrective appliances for the foot
- Services for which a third-party is or may be responsible
- Services that are not medically necessary

Other Covered Services (This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)

- Bariatric services
- Chiropractic care
- Hearing aids
- Infertility
- Private duty nursing
- Routine eye care
- Routine foot care
- Temporomandibular Joint Disorder (TMJ)
- Weight loss programs as part of a program approved by SelectHealth

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. An individual policy may also provide different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 800-538-5038 or visit **www.opm.gov.insure/health**.

Your Appeal 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 844-208-9012.

Does this Coverage Provide Minimum Essential Coverage?:

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." Coverage under this plan qualifies as minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?:

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Language Access Services:

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-538-5038

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,180
- **Patient pays** $360

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$210
Coinsurance	$0
Limits or exclusions	$150
Total	**$360**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,790
- **Patient pays** $610

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$400
Coinsurance	$130
Limits or exclusions	$80
Total	**$610**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.