Date: **Subscriber ID:**

Dear Member,

This letter states changes to Select Health FEHB plans and premium rates for the 2026 plan year.

Changes to Standard and High Deductible Health Plan (HDHP) Options

- The Plan will exclude transgender surgeries and hormone treatments when rendered for the purpose of gender transition.
- The Plan will cover iatrogenic and cryopreservation storage costs for up to 12 months.
- The Plan will remove age limits and increase the frequency associated with acquiring External Hearing aids to every 5 years.

Changes to Standard Option Only

- The Plan will increase the member in-network catastrophic out-of-pocket maximum to $7,500 for Self Only and $15,000 for Self Plus One and Self and Family.
- The Plan will increase the point of service out-of-network catastrophic out-of-pocket maximum to $10,000 Self Only, $20,000 Self Plus One and Self and Family.
- The Plan will increase the cost share for maternity/delivery to $500 per admission.
- The Plan will increase the cost share for emergency room visits to $250 copay per visit after deductible for both in-network and out-of-network facilities.
- The Plan will remove access to applied behavior analysis (ABA) services on the point of service feature when ABA services are rendered out-of-network.
- The Plan has added a pharmacy-specific deductible of $150 per person or $300 per family.

- The Plan will increase the cost share for Tier 2 (30-day) prescription drugs to $100 copay after pharmacy deductible.

- The Plan will increase the cost share for the Tier 2 (90-day) prescription drugs to $200 copay after pharmacy deductible.

- Your share of the premium rate will decrease for Self Only, Self Plus One, & Self and Family. See rate table at the end of the brochure.

Changes to HDHP Option Only

- The Plan will increase the deductible to $2,000 Self Only/$4,000 Family.

- The Plan will increase the catastrophic out-of-pocket maximum to $7,500 Self Only and $15,000 Self Plus One and Self and Family.

- The Plan will increase the HSA premium pass-through to $100 a month for Self Only and $200 a month for Self Plus One and Self and Family enrollment.

- The Plan will change the Inpatient hospital facility cost share to 3% of the allowed amount after deductible.

- The Plan will change the Outpatient hospital and facility cost share to 3% of the allowed amount after deductible.

- The Plan will increase the Maternity and Delivery benefit to $250 per admission after deductible.

- The Plan will increase the cost share for Tier 2 (30-day) prescription drugs to 30% up to $350 after deductible.

- The Plan will increase the cost share for Tier 3 (30-day) prescription drugs to 50% up to $350 after deductible.

- The Plan will increase the cost share for Tier 2 (90-day) prescription drugs to 30% up to $700 after deductible.

- The Plan will increase the cost share for Tier 3 (90-day) prescription drugs to 50% up to $700 after deductible.

- Your share of the premium rate will increase for Self Only, Self Plus One, & Self and Family. See rate table at the end of the brochure.

2026 Rate Information

Type of Enrollment	Enrollment Code	Premium Rate	
		Biweekly	Monthly
		Your Share	Your Share
Standard Option Self Only	SF4	$106.47	$230.69
Standard Option Self Plus One	SF6	$234.24	$507.52
Standard Option Self and Family	SF5	$286.71	$621.21
HDHP Option Self Only	WX1	$98.03	$212.41
HDHP Option Self Plus One	WX3	$215.68	$467.30
HDHP Option Self and Family	WX2	$245.09	$531.03
These rates do not apply to all Enrollees. If you are in a special enrollment category, please refer to the FEHB Program website or contact or the agency or Tribal Employer that maintains your health benefits enrollment.			

SBCs and Brochure

This Plan's SBCs and brochure are available on the internet at **selecthealth.org/fehb**. A paper copy is also available, free of charge, by calling **844-345-3342** (a toll-free number). To find out more information about plans available under the FEHB Program, including SBCs for other FEHB plans, please visit **opm.gov/fehbcompare**.

This is a brief description of the features of Select Health. Before making a final decision, please read the Plan's Federal brochure (RI 73-865). All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochure.

Member Services

If you have questions, call Select Health Member Services at **844-345-3342** weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users, please call **711**.

Sincerely,

Select Health

Fair Treatment Notice
Select Health 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, and/or veteran status.

This information is available for free in other languages and alternate formats by contacting Select Health Medicare: **855-442-9900 (TTY: 711)** / Select Health: **844-345-3342**.

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