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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000/Self Only $4,000/Self Plus One $4,000/Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,500/Self Only $15,000/Self Plus One $15,000/Self and Family	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.
What is not included in the out-of-pocket limit?	Premiums, and health care this Plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.selecthealth.org/fehb.com or call 1-844-345-FEHB for a list of network providers.	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.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Participating Provider (You will pay the most, plus you may be balance	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10/visit	Not covered	None
	Specialist visit	$30/visit	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for minor diagnostic tests; 3% for major diagnostic test	Not covered	Free-standing imaging centers (FSIC) Nothing, after deductible
	Imaging (CT/PET scans, MRIs)	3% for major diagnostic tests	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://selecthealth.rxeob.com/mdb_sh/public/drugsearch	Standard Tier 1 (Generic drugs)	$7/prescription	Not covered	Deductible does not apply to certain preventive prescription drugs. Certain limitations apply. Mail Order/Maintenance Medications - 90-day supply
	Standard Tier 2 (Preferred brand drugs)	30% coinsurance up to $350/prescription	Not covered	
	Standard Tier 3 (Non-preferred brand drugs)	50% coinsurance up to $350/prescription	Not covered	
	Mail-order/Maintenance Tier 1 (Generic drugs)	$7/prescription	Not covered	
	Mail-order/Maintenance Tier 2 (Preferred brand drugs)	30% coinsurance up to $700/prescription	Not covered	
	Mail-order/Maintenance Tier 3 (Non-preferred brand drugs)	50% coinsurance up to $700/prescription	Not covered	

	Specialty drugs	30% coinsurance	Not covered	Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services. You must use Intermountain Specialty Pharmacy to acquire Tier 4 drugs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Participating Provider (You will pay the most, plus you may be balance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	3% coinsurance per day/ Outpatient Hospital	Not covered	Benefits may be reduced or denied by 50% for failure to obtain preauthorization for certain services.
	Physician/surgeon fees	No charge	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	$200/visit	$200/visit	
	Emergency medical transportation	$100/transport	$100/transport	Emergencies only.
	Urgent care	$30/visit	$30/visit	Applies to urgent care facilities only.
If you have a hospital stay	Facility fee (e.g., hospital room)	3% coinsurance/ admission Nothing after deductible for hospital level care at home	Not covered	Benefits may be reduced or denied by 50% for failure to obtain a preauthorization for certain services. Up to 40 days per calendar year for all therapy types combined for inpatient rehabilitation.
	Physician/surgeon fees	No charge	Not covered	Benefits may be reduced or denied by 50% for failure to obtain a preauthorization for certain services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10/visit for office visits, 3% coinsurance for outpatient	Not covered	None
	Inpatient services	3% coinsurance/ admission	Not covered	Benefits may be reduced or denied by 50% for failure to obtain a preauthorization for certain services.

If you are pregnant	Office visits	$10/visit after deductible	Not covered	Single office visit copayment applies to confirm pregnancy. No additional cost sharing for subsequent prenatal or postpartum care. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	3% coinsurance/ admission	Not covered	Benefits may be reduced or denied by 50% for failure to obtain a preauthorization for certain services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Participating Provider (You will pay the most, plus you may be balance	
	Childbirth/delivery facility services	$250/admission	Not covered	Benefits may be reduced or denied by 50% for failure to obtain a preauthorization for certain services.
If you need help recovering or have other special health needs	Home health care	3% coinsurance/day	Not covered	Benefits may be reduced or denied by 50% for failure to obtain a preauthorization for certain services.
	Rehabilitation services	$30/visit	Not covered	Benefits may be reduced or denied by 50% for failure to obtain a preauthorization for certain services. Preauthorization is required after 20 visits for each therapy in an outpatient setting.
	Habilitation services	$30/visit	Not covered	Benefits may be reduced or denied by 50% for failure to obtain a preauthorization for certain services. Preauthorization is required after 20 visits for each therapy in an outpatient setting.
	Skilled nursing care	3% coinsurance/ admission	Not covered	Up to 60 days per calendar year. Benefits may be reduced or denied by 50% for failure to obtain a preauthorization for certain services.
	Durable medical equipment	5% coinsurance	Not covered	Benefits may be reduced or denied by 50% for failure to obtain a preauthorization for certain services.

	Hospice services	3% coinsurance/day	Not covered	Benefits may be reduced or denied by 50% for failure to obtain a preauthorization for certain services.
If your child needs dental or eye care	Children's preventive eye exam	No charge	Not covered	Deductible doesn't apply
	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
- Gender affirming surgery
- Drugs to treat gender dysphoria
- 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.)

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

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 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**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,000**
Specialist *copayment*	**$30**
Hospital (facility) *copayment*	**$300**
Other *copayment*	**$0**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$330
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,330**

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

The plan's overall deductible	**$2,000**
Specialist *copayment*	**$30**
Hospital (facility) *copayment*	**$150**
Other *copayment*	**$7**

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	**$7,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$2,080**

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

The plan's overall deductible	**$2,000**
Specialist *copayment*	**$30**
Hospital (facility) *copayment*	**$150**
Other *copayment*	**$200**

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	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$260
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,260**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination 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, sexual orientation, gender identity or expression, and/or veteran status.

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 Select Health Member Services at 844-345-3342 or Select Health 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 Select Health 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).

Language Access Services

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Select Health.

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 Select Health

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Select Health.

Korean

통지: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Select Health. 번호로 전화해

Nepali

ध्यान दिनुहोस: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छ। Select Health मा फोन गर्नुहोस।

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Select Health.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Select Health.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните Select Health.

French

ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez Select Health.

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。Select Health. まで、お電話にてご連絡ください。

Amharic

ማሳሰቢያ፡ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎቶች ያለክፍያ ለእርስዎ ይገኛሉ። Select Health ን ያናግሩ።

Serb-Croatian

ПАЖЊА: Ако говорите Српски, бесплатне услуге пмоћи за језик, биће вам доступне. Контактирајте Select Health.

Arabic

تامدخ كل رفوتتسف، ىبرع ثدحتت تنك اذإ: هيبنت ب لصتا .انًاجم ةيوغللا ةدعاسملا Select Health.

Persian

تامدخ ،دينكيم تبحص ينک دراو ار نابز هب رگا: هجوت اب تسامش رايتخا رد ناگيار تروصب ،ينابز کمک. ديريگب سامت .Select Health

Thai

หมายเหตุ: หากคุณพูด ใส่ภาษา, การบริการภาษาโดยไม่มีค่าใชจ ่าย มีพรอ้ มบริการใหกั ับคุณ ติดต่อ Select Health

Select Health: 1-844-345-3342

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