SelectHealth Plan

www.selecthealth.org/fehb

Member Services 844-345-FEHB

selecthealth

2021

A Health Maintenance Organization Standard Option and a High Deductible Health Plan

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9 for details. This Plan is accredited.
See page 14.

IMPORTANT
- Rates: Back Cover
- Changes for 2021: Page 17
- Summary of Benefits: Page 129

Serving:

Utah - Statewide

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 16 for requirements.

Enrollment codes for this Plan:

SF4 Standard Option - Self Only
SF6 Standard Option - Self Plus One
SF5 Standard Option - Self and Family

WX1 High Deductible Health Plan - Self Only
WX3 High Deductible Health Plan - Self Plus One
WX2 High Deductible Health Plan - Self and Family

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-865

Important Notice from SelectHealth Plan About
Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the SelectHealth Plan prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and we will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 (TTY: 800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY: 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of SelectHealth Plan under contract (CS 2925) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This plan is underwritten by SelectHealth Plan. Member Services may be reached at 844-345-FEHB or through our website: www.selecthealth.org/fehb. The address for SelectHealth Plan administrative offices is:

SelectHealth Plan
5381 Green St.
Murray, UT 84123

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2021, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2021 and changes are summarized on page 17. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered family member, "we" means SelectHealth Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB Plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 844-345-FEHB and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to

www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure

accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26). A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

SelectHealth Plan complies with all applicable Federal civil rights laws, including Title VII of the Civil Rights Act of 1964.

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management

Healthcare and Insurance

Federal Employee Insurance Operations

Attention: Assistant Director, FEIO

1900 E Street NW, Suite 3400-S

Washington, D.C. 20415-3610

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions, and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medication and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit

- www.jointcommission.org/speakup.aspx The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers The Agency for Healthcare Research and Quality provides information about patient safety, choosing quality health care providers, and improving the quality of care you receive.
- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you brochures for other plans and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We don’t determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is for you and one eligible family member. Self and Family coverage is for you and one eligible family member, or you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) – such as marriage, divorce, or the birth of a child – outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you in Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2021 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2020 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage with your new plan.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire** — When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends** — You will receive an additional 31 days of coverage, for no additional premium, when:
  - Your enrollment ends, unless you cancel your enrollment; or
  - You are a family member no longer eligible for coverage.

  Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

  You may be eligible for spouse equity coverage or assistance with enrolling in a conversion policy (a non-FEHB individual policy).

- **Upon divorce** — If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)** — If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

  You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage** — You may convert to a non-FEHB individual policy if:
  - Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
  - You decided not to receive coverage under TCC or the spouse equity law; or

- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-538-5038 or visit our website at www.selecthealth.org.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and care management meet nationally recognized standards. SelectHealth Plan holds the following accreditation: National Committee for Quality Assurance (www.ncqa.org). To learn more about the plan's accreditation please visit the following website: www.ncqa.org. We require you to see specific physicians, hospitals, and other providers (including lab and pathology providers) that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you a choice of enrollment in a Standard Option or a High Deductible Health Plan (HDHP).

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive urgent and/or emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our Standard Option

You do not have to select a Primary Care Physician (PCP); you may self-refer to Plan specialists. However, we recommend that you select a PCP to coordinate all of your medical care. A PCP should practice one of the following disciplines: General Practice, Family Medicine, Internal Medicine, Obstetrics/Gynecology (OB/GYN), or Pediatrics. **You are responsible for making sure that a provider is a participating provider**. To contact Member Services, call 844-345-FEHB weekdays, from 7 a.m. to 8 p.m., and Saturdays, from 9 a.m. to 2 p.m., or visit our website at www.selecthealth.org/fehb. Representatives are available during extended hours to answer questions and help resolve concerns.

We have Open Access benefits

Our HMO offers open access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (deductible, if applicable, copayments, coinsurance, and non-covered services and supplies).

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services

Preventive care services are generally covered with no cost sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, excluding specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not received VA (except for veterans with a service-connected disability) or Indian Health Service (IHS) benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable - you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles, coinsurance, and copayments, to no more than **$7,000** for Self Only enrollment, and **$14,000** for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Health education resources and accounts management tools

HealthEquity will send you a welcome packet once your account has been established. Access account support materials and other educational resources by visiting the HealthEquity website at www.healthequity.com or call them directly for assistance at 866-346-5800.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Intermountain Healthcare, our parent company, is a not-for-profit health system based in Salt Lake City with with nearly 40,000 employees. Since 1984, SelectHealth Plan has been providing coverage for high-quality healthcare for the communities of Utah;
- Not-for-profit

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our SelectHealth Plan website at www.selecthealth.org/fehb. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 844-345-FEHB, or write to P.O. Box 30192 Salt Lake City, UT 84130-0192. You may also visit our website at www.selecthealth.org/fehb.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our SelectHealth Plan website at https://selecthealth.org to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is:

Utah - Statewide

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for urgent and/or emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or complete the SelectHealth Plan Dependent Address Change Form to access out of area extended coverage. See Section 5(h) to learn more about the Out of Area Child(ren) Dependent Coverage benefit. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2021

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5. Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to Standard and HDHP Options

- Telehealth services for both non-urgent care and urgent care (via Intermountain Connect Care) is covered at zero cost share to the member. The deductible does not apply to telehealth services.
- Birthing centers are limited to a hospital or a participating birthing center connected to a hospital either through a bridge, ramp, or adjacent to the labor and delivery unit. This includes all Provider and/or Facility charges related to the delivery.
- In addition to the services listed in this brochure, the deductible is waived for the following services: Retinopathy screening for diabetes; Hemoglobin A1c testing for diabetes; Peak flow meter for asthma; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders; Low-density lipoprotein (LDL) testing for heart disease; certain prescription drugs for conditions, such as: Asthma & COPD, Cardiovascular/Antladrenergics, Cardiovascular, Cholesterol, Diabetes-Insulin, Diabetes-Non-Insulin, Mental Health, and Osteoporosis.
- Preauthorization is now required for certain vein procedures.
- Home visits are now covered for participating providers. The cost shares for office visits will be $15 Primary care physician (PCP), $35 Specialist for the Standard Option and $10 PCP, $30 Specialist for the HDHP Option.
- Allogeneic blood or marrow stem cell transplants for Infantile malignant osteopetrosis, Kostmann's syndrome, or Sickle cell anemia transplants are no longer covered.
- Cardiac rehabilitation is covered at 100% after deductible. Previously, the cost shares were 15% of the allowed amount after deductible for the Standard Option and $150 per day after deductible for the HDHP Option.
- Completion of a health risk assessment is no longer required to qualify for a wellness incentive. Members are now only required to be age 18 or older and enrolled in a SelectHealth Plan FEHB plan.
- The "Weigh to Health" name has changed to "Intermountain Weight Management Program." Benefits are provided for both adults and children. Previously, the program was limited to adults.
- The Plan will have have a closed formulary in which all new drugs are reviewed prior to being added to the formulary. A non-formulary drug prescribed by a Plan doctor will require prior authorization to be covered by the Plan. Previously, the Plan had an open formulary, in which the plan covered non-formulary drugs prescribed by a Plan doctor.
- Prescription drug refills are allowed after 75 percent of the last refill has been used for a 30-day supply (or greater than a 30-day supply). Some exceptions may apply. Previously refills were allowed after 80 percent of the last refill had been used for a 30-day supply (or greater than a 30-day supply).

Changes to Standard Option only

- Allergy testing is no longer subject to the deductible. See page 35.
- Your share of non-postal premium will increase for Self Only, Self Plus One, and Self and Family. See page 134.

Changes to HDHP Option only

- Inpatient Hospice is covered $150 per day up to $750 per admission. The cost shares for outpatient services will be $150 day. Previously this benefit was covered at $150 per day. See page 98.
- An administration fee of $20 is charged by the Plan's contractor, HealthEquity, when a member fails to notify the Plan within 30 days of enrollment that an HRA is needed instead of an HSA. See page 69.
- Drugs obtained at a non-Plan pharmacy, except for urgent and/or emergencies out-of-area, are not covered. See page 105.
- Your share of non-postal premium will increase for Self Only, Self Plus One, and Self and Family. See page 134.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 844-345-FEHB or write to us at P.O. Box 30192 Salt Lake City, UT 84130-0192. You may also request replacement cards through our website at www.selecthealth.org/myhealth.

Where you get covered care

You must receive care from "Plan providers" and "Plan facilities." You will only pay a deductible (if applicable), copayments, and/or coinsurance based on your benefit plan selection. You can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network. Services rendered by non-participating providers are not covered, unless they are urgent and/or emergency related.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website at www.selecthealth.org/fehb.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website at www.selecthealth.org/fehb.

What you must do to get covered care

Your network includes Select Med® providers in Utah. To receive benefits, you must use doctors, clinics, and hospitals that participate in your network. Services received from non-participating providers are not covered, with the exception of urgent and emergency care. To find a participating provider visit www.selecthealth.org/fehb or call Member Advocates^{SM}. A copy of the Provider and Facility Directory is available upon request.

You and each family member may choose a primary care physician, though one is not required. Your primary care physician can provide or arrange for most of your health care.

- **Primary care**

Your primary care physician can be a Family Practitioner, Internal Medicine Doctor, Pediatrician, Obstetrician or Gynecologist (OB/GYN). Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan and you need help finding a new one, Member Advocates can help you find the right care for your needs. Call 800-515-2220 weekdays, from 7 a.m. to 8 p.m., and Saturdays, from 9 a.m. to 2 p.m.

- **Specialty care**

You may see a specialist for needed care.

Here are some things you should know about specialty care:

- If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call us and we will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the FEHB Program and you enroll in another FEHB program plan; or
  - reduce our service area and you enroll in another FEHB plan;

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Participating providers will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call Member Services immediately at 844-345-FEHB. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Preauthorization is prior approval from SelectHealth Plan for certain services. Obtaining preauthorization does not guarantee coverage. Your benefits for the preauthorized services are subject to the eligibility requirements, limitations, exclusions and all other provisions of the Plan.

Participating providers and facilities are responsible for obtaining preauthorization on your behalf; however, you should verify that they have obtained preauthorization prior to receiving services.

Members are required to obtain prior approval for services rendered by a non-participating provider. Without an approved preauthorization, services will be denied.

The following services require preauthorization:

- Advanced imaging including magnetic resonance imaging (MRI), computerized tomography (CT) scans, positron emission tomography (PET) scans, and cardiac imaging;
- All admissions to facilities, including rehabilitation, transitional care, skilled nursing, residential treatment centers, and all hospitalizations that are not for urgent or emergency conditions

- All non-routine obstetrics admissions, maternity stays longer than two days for a normal delivery or longer than four days for a cesarean section, and deliveries rendered by a non-participating provider (whether inside or outside of the service area) unless the situation is deemed to be an urgent or emergency situation;
- Home healthcare, hospice care, and private duty nursing;
- Gender reassignment surgeries;
- Joint replacement;
- Surgeries on vertebral bodies, vertebral joints, spinal discs;
- Pain management/pain clinic services;
- All services obtained outside of the United States unless for an urgent condition, or an emergency condition;
- Gene therapy and certain genetic testing, including BRCA testing;
- Certain ultrasounds;
- Certain vein procedures;
- Certain radiation therapies;
- Certain sleep studies;
- Certain medical oncology drugs;
- Continuous glucose monitors;
- Hysterectomy;
- Tonsillectomy;
- Adenoidectomy;
- Vision rehabilitation therapy;
- Outpatient rehabilitation and habilitative therapy services after 10 visits;
- The following durable medical equipment (DME):
  - Insulin pumps
  - Continuous positive airway pressure (CPAP) and bilevel positive airway pressure (BiPAP);
  - Prosthetics (except eye prosthetics)
  - Negative pressure wound therapy electrical pump (wound vac)
  - Motorized or customized wheelchairs, and
  - DME with a purchase price over $5,000
- Growth hormone therapy (GHT)
- Cochlear implants, bone anchored hearing aids, related services and supplies
- Organ transplants
- Certain injectable drugs and specialty medications (even when Medicare is your primary insurance);
- The medications listed on selecthealth.org/pharmacy-benefits
- In addition to these services, participating providers must preauthorize other services as specified in SelectHealth Plan medical policy.

If you have a question about the preauthorization requirement of a particular item, drug, or service, or for a copy of the prescription drug list, please contact Member or Pharmacy Services at 844-345-FEHB.

How to request preauthorization for an admission or get prior authorization for other services

First, your physician, your hospital, you, or your representative, must call us at 844-345-FEHB before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- Enrollee's name and Plan identification number;
- Patient's name, birth date, identification number and phone number;
- Reason for hospitalization, proposed treatment, or surgery;
- Name and phone number of admitting physician;
- Name of hospital or facility; and
- Number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notifications within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us toll-free at 844-208-9012. You may also call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us toll-free at 844-208-9012. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

  A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **The Federal Flexible Spending Account Program - *FSAFEDS***

  - **Health Care FSA (HCFSA) -** Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
  - **FSAFEDS** offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Emergency inpatient admission**

  If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must contact SelectHealth Plan once the condition has been stabilized, or as soon as reasonably possible; and, if you are in a non-participating facility, once the emergency condition has been stabilized, you may be asked to transfer to a participating facility in order to continue receiving participating benefits.

- **Maternity care**

  You do not need to preauthorize a maternity admission for a routine delivery. All non-routine obstetrics admissions and maternity stays longer than two days for a normal delivery or longer than four days for a cesarean section require preauthorization. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for preauthorization of additional days for your baby.

  Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

  Deliveries rendered by a non-participating provider (whether inside or outside of the service area) will be denied unless the situation is deemed to be an urgent or emergency situation.

- **If your treatment needs to be extended**

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the preauthorization rules when using non-network facilities

Services rendered by non-participating providers are not covered unless urgent and/or emergency related. If you need assistance finding a participating provider, contact SelectHealth Plan Member Advocates at 800-515-2220 weekdays, from 7 a.m. to 8 p.m., and Saturdays, from 9 a.m. to 2 p.m. To access the online provider directory, visit www.selecthealth.org/fehb.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding preauthorization of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Preauthorize your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Cost for Covered Services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (i.e., deductible, coinsurance and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay when you receive covered services.

Example: A person on the Standard Option plan seeing a primary care physician would pay a copayment of $15 per office visit and $35 per office visit with a specialist.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care.

Example: A person on the Standard Option Plan would pay a 15% coinsurance for outpatient facility services.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count towards any deductibles.

- The calendar year deductible is $250 for Self Only enrollment, $500 for Self Plus One, or $500 for Self and Family enrollment under the Standard Option plan. Under a Self Plus One or Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses reach $500.
- The calendar year deductible is $1,500 for Self Only enrollment, $3,000 for Self Plus One, or $3,000 for Self and Family enrollment under the High Deductible Health Plan. Under a Self Plus One or Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses reach $3,000.

Note: If you change plans during Open Season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options within this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your prior option to the deductible of your new option.

In addition to the services listed in this brochure, the deductible is waived for the following services:

- Retinopathy screening for diabetes;
- Hemoglobin A1c testing for diabetes;
- Peak flow meter for asthma;
- International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders;
- Low-density Lipoprotein (LDL) testing for heart disease; and
- Certain prescription drugs, such as: Asthma Mental Health, & Osteoporosis

Differences between our Plan allowance and the bill

Any charges from providers and facilities that exceed the SelectHealth Plan allowed amount for covered services.

All deductible, copay and coinsurance amounts are based on the allowed amounts and not on the provider's billed charges. Participating providers and facilities are under contract to accept the SelectHealth Plan allowed amount as payment in full for covered services. Non-participating providers and facilities have not agreed to accept the allowed amount for covered services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth Plan pays for covered services. These fees are called excess charges, and they do not apply to your out-of-pocket maximum.

Your catastrophic protection out-of-pocket maximum

After your out-of-pocket expenses, including any applicable deductible, copayments and coinsurance, total $5,000 for Self Only or $10,000 for Self Plus One, or Self and Family enrollment in the HDHP Option; or $5,500 for Self Only or $11,000 for Self Plus One, or Self and Family enrollment in the Standard Option; in any calendar year, you do not have to pay any more for covered services.

Example Scenario for a Standard Option plan: Your plan has a $5,500 Self Only maximum out-of-pocket limit and an $11,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $5,500 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $11,000, a second family member, or an aggregate of other eligible family members, will continue to accrue additional out-of-pocket qualified medical expenses up to a maximum of $5,500 for the calendar year before their qualified medical expenses will begin to be covered in full.

However the deductible, copayments and coinsurance (if applicable) for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay the deductible, copayments and coinsurance for these services:

- Infertility
- Expenses from utilizing non-participating providers

Be sure to keep accurate records and receipts of your deductibles, copayments and coinsurance to ensure the Plan's calculation of your out-of-pocket maximum is reflected accurately.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan’s catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan’s catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year’s catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year’s benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your prior plan option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than the governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Standard Option Benefits

See page 17 for how our benefits changed this year. Page 129 is a benefits summary of the Standard Option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. Standard Option Benefits Overview

This Plan offers a Standard Option benefit package, which is described in Section 5. Make sure that you review your plan option benefits.

The Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about Standard Option benefits, contact us at 844-345-FEHB or on our website at www.selecthealth.org/fehb.

Unique features are outlined below.

- **Standard Option**

The calendar year deductible is $250 per person under the Standard Option plan. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses reach $250. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses reach $500. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses reach $500.

Office visits are subject to copayments ($15 for primary care providers and $35 for specialists). Members do not need to have referrals to see specialists. When a coinsurance applies, the portion you will pay is 15% of the Plan's allowed amount after the deductible. You must use participating providers for your care to be eligible for benefits, except for urgent and/or emergency services.

- **Wellness incentive**

Participate in the FEHB wellness incentive program to improve your health and earn an incentive. Eligible members must be age 18 or older and enrolled on a SelectHealth Plan FEHB plan option. Log in to the SelectHealth Plan Portal at www.selecthealth.org/fehb to access the health risk assessment.

Receive up to a combined total of either $75 per person or $200 per family for completion of qualified wellness events. Contact Member Services at 844-345-FEHB or visit www.selecthealth.org/fehb for more information.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility deductible (if applicable), copay or coinsurance applies to services that appear in this section but are performed inpatient, in an ambulatory surgical center or the outpatient department of a hospital.
- Standard Option: The calendar year deductible is $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). We indicate when the deductible applies. The out of pocket maximum is $5,500 per person ($11,000 per Self Plus One enrollment, or $11,000 per Self and Family).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR CERTAIN SERVICES, SUPPLIES, AND DRUGS.** Please refer to Section 3 to be sure which services require preauthorization.

Benefit Description	You Pay
Note: The calendar year deductible applies only when indicated below.	
Diagnostic and treatment services	**Standard**
Professional services of physicians • In physician's office, including minor surgical procedures • Office medical consultations • Second surgical opinion • Advanced care planning • Home visits	$15 per office visit to a primary care physician $35 per office visit to a specialist
In an urgent care center	$35 Urgent care or Intermountain InstaCare visit $15 Intermountain KidsCare visit
• During a hospital stay • In a skilled nursing facility • Private duty nursing Note: Major surgery is a surgical procedure having one or more of the following characteristics: (A) performed within or upon the contents of the abdominal, pelvic, cranial or thoracic cavities; (B) typically requiring general anesthesia; (C) has a level of difficulty or length of time to perform which constitutes a hazard to life or function of an organ or tissue; or (D) requires the special training to perform. Any surgical procedure not classified as major surgery is considered a minor surgical procedure. Note: Private duty nursing requires preauthorization from your Physician. See page 19.	15% of the allowed amount after deductible

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay
Diagnostic and treatment services (cont.)	**Standard**
Applied behavior analysis (ABA) Office visit services performed by a board-certified physician in neurology or pediatrics with experience in diagnosing autism spectrum disorder: • Evaluation, management, and assessment services necessary to determine whether a member has an autism spectrum diagnosis Behavior training, management, and ABA therapy services by certified therapists: • Care rendered in the home or other clinical setting Note: For information on physical/occupational/speech therapy benefits, see page 36. For information on the mental health ABA benefits, see Section 5 (e) *Mental Health and Substance Use Benefits*. See page 53.	$15 per office visit to a primary care physician $35 per office visit to a specialist 15% of the allowed amount after deductible for outpatient services
Telehealth services	**Standard**
Urgent Care/Intermountain Connect Care telehealth services – Intermountain Connect Care℠ is a convenient way to talk to a provider about urgent medical issues, no appointment necessary. Use your smartphone, tablet, or computer to connect to a provider within minutes. Download the app or visit www.intermountainconnectcare.org to get started. Providers at Connect Care can help you with: • Cough • Ear pain • Eye infection • Joint pain/strain • Lower back pain • Minor burns/rashes/skin infections • Sinus pain/pressure • Seasonal allergies • Sore throat • Urinary pain	Nothing, Deductible waiver applies to telehealth services
All non-urgent telehealth services - Telehealth services are covered in accordance with the SelectHealth Plan medical policy when rendered by a participating provider. (Deductible does not apply to telehealth services)	Nothing, Deductible waiver applies to telehealth services
Lab, X-ray and other diagnostic tests	**Standard**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms	Nothing for minor diagnostic tests 15% of the allowed amount after deductible for major diagnostic tests

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You Pay
Lab, X-ray and other diagnostic tests (cont.)	**Standard**
• CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG Note: Preauthorization is required for certain diagnostic testing. See page 19. Note: Major and minor diagnostic tests are based on several considerations such as the invasiveness and complexity of the test, the level of expertise required to interpret or perform the test, and where the test is commonly performed. If you have a question about the category of a particular test, please contact Member Services at 844-345-FEHB.	Nothing for minor diagnostic tests 15% of the allowed amount after deductible for major diagnostic tests
Injectable drugs (medical)	**Standard**
Injectable, implantable, and IV therapy drugs rendered in a provider's office or in a facility setting Note: Preauthorization is required for certain injectable drugs and specialty medications. See page 19. If you have questions about preauthorization requirements, please call Member Services at 844-345-FEHB.	30% of the allowed amount after deductible
Preventive care, adult	**Standard**
Routine physical once every year The following preventive services are covered at the time interval recommended at each of the links below. • Immunizations such as Pneumococcal, influenza, shingles, tetanus/DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Individual counseling on prevention and reducing health risks • Well woman care such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Woman preventive care services please visit the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/	Nothing
Routine mammogram - covered for women	Nothing
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule.	Nothing
Nutritional therapy Note: Medical nutritional therapy is a comprehensive nutrition service provided by dietitians with a state license or statutory certification.	Nothing

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	**Standard**
Note: After the 5th visit, nutritional therapy is covered under the inpatient, outpatient, or office visit benefit, depending on where the therapy is rendered. See Section 5(a) Diagnostic and treatment services on page 29. For questions regarding specific medical benefits, please contact Member Services at 844-345-FEHB.	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member deductible, copayments and coinsurance.	
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	**Standard**
• Well-child visits, examinations, and other preventive services as described in the Bright Futures Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Immunizations such as DRaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the CDC website at https://www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of preventive care services recommended under the USPSTF online at https://www.uspreventiveservicestaskforce.org	Nothing
Nutritional therapy Note: Medical nutritional therapy is a comprehensive nutrition service provided by dietitians with a state license or statutory certification. Note: After the 5th visit, nutritional therapy is covered under the inpatient, outpatient, or office visit benefit, depending on where the therapy is rendered. See Section 5(a) Diagnostic and treatment services on page 29. For questions regarding specific medical benefits, please contact Member Services at 844-345-FEHB.	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member deductible, copayments and coinsurance.	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*

Benefit Description	You Pay
Maternity care	**Standard**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women • Delivery • Postnatal care	A single office visit copay of $15 when pregnancy is confirmed; nothing for subsequent prenatal or postpartum care
Breastfeeding support, supplies and counseling for each birth	Nothing
Note: Here are some things to keep in mind: • You do not need to preauthorize your vaginal or cesarean delivery; see page 19 for other circumstances, such as extended stays for you or your baby. • Deliveries rendered by a non-participating provider (whether inside or outside of the service area) will be denied unless the situation is deemed to be an urgent or emergency situation. • You may remain in the hospital up to 48 hours after vaginal delivery and 96 hours after a or cesarean delivery. All non-routine obstetric admissions and maternity stays longer than 48 hours after a vaginal delivery and 96 hours after a cesarean delivery require preauthorization from your physician. We will extend your inpatient stay if medically necessary. See page 19. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. Note: Childbirth in any place other than a Hospital or a participating birthing center connected to a Hospital either through a bridge, ramp, or adjacent to the labor and delivery unit is not covered. This includes all Provider and/or Facility charges related to the delivery.	
Not covered: • *Home delivery*	*All charges*
Family planning	**Standard**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: • Tubal ligation. See Section 5(b) *Surgical procedures*. See page 41. • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera)	Nothing

Family planning - continued on next page

Benefit Description	You Pay
Family planning (cont.)	**Standard**
• Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit. Vasectomies, see Section 5(b). See page 41.	Nothing
Genetic testing: • Prenatal testing when performed as part of an amniocentesis to assess specific chromosomal abnormalities in women at high risk for inheritable conditions that can lead to significant immediate and/or long-term health consequences to the child after birth: • Neonatal testing for specific inheritable metabolic conditions (e.g. PKU) • When the member has more than five-percent probability of having an inheritable genetic condition and has signs or symptoms suggestive of a specific condition or a strong family history of the condition (defined as two or more first-degree relatives with the condition) and results of the testing will directly affect the patient's treatment • Pre-implantation embryonic genetic testing performed to identify an inherited genetic condition known to already exist in either parent's family which has the potential to cause serious and impactful medical conditions for the child Note: Gene therapy and genetic testing requires preauthorization from your physician. See page 19. Note: Kymriah and Luxturna are covered for certain gene therapy treatments. Contact the Plan if you have a coverage question, please contact Member Services at 844-345-FEHB. See page 31. Note: Genetic counseling is covered when provided by a participating provider.	15% of the allowed amount after deductible
BRCA testing Note: BRCA testing requires preauthorization from your physician. See page 19.	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling services not shown as covered*	*All Charges*
Infertility services	**Standard**
Infertility is a condition resulting from a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. Services for the diagnosis of infertility are only covered in limited circumstances, including fulguration of ova ducts, hysteroscopy, hysterosalpingogram, certain laboratory tests, diagnostic laparoscopy, and some imaging studies. For a full list of covered infertility services, please contact SelectHealth Plan.	50% of the allowed amount after deductible

Infertility services - continued on next page

Benefit Description	You Pay
Infertility services (cont.)	**Standard**
Note: Infertility does not apply to the out-of-pocket maximum. Infertility coverage is limited to a maximum plan payment of $1,500 per calendar year.	50% of the allowed amount after deductible
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *Artificial insemination (AI), such as:* • *Intravaginal insemination (IVI)* • *Intracervical insemination (ICI)* • *Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Oncofertility* • *Fertility drugs*	*All charges*
Allergy care	**Standard**
• Testing	$15 copay to a primary care physician for testing $35 copay to a specialist for testing
• Allergy treatment • Allergy injections • Allergy serum	15% of the allowed amount after deductible
Not covered: • *Certain allergy tests and treatments are not covered. Contact SelectHealth Plan Member Services for details.*	*All charges*
Treatment therapies	**Standard**
• Chemotherapy and radiation therapy Note: Certain radiation therapies and medical oncology drugs require preauthorization. See page 19. Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b). • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy Note: Enteral formula requires preauthorization from your physician. See page 19. • Growth hormone therapy (GHT)	15% of the allowed amount after deductible

Treatment therapies - continued on next page

Benefit Description	You Pay
Treatment therapies (cont.)	**Standard**
Note: Growth hormone therapy is covered under the prescription drug benefit and requires preauthorization. See page 19 and Section 5(f) *Prescription Drug Benefits* on page 56. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services under *You need prior Plan approval for certain services* on page 19. • Applied behavior analysis (ABA) - children with autism spectrum disorder Note: For information on the mental health ABA benefits, see Section 5(e) Mental Health and Substance Use Disorder Benefits. See page 53.	15% of the allowed amount after deductible
Cardiac rehabilitation following qualifying event/condition	Nothing, after deductible
Proton beam therapy in the following limited circumstances: • Chordomas or chondrosarcomas arising at the base of the skull or along the axial skeleton without distant metastases; • Other central nervous system tumors located near vital structures; • Pituitaryneoplasms; • Uveal melanomas confined to the globe (not distant metastases); or • In accordance with SelectHealth Plan medical policy	15% of the allowed amount after deductible
Not covered: • *Neutron beam therapy* • *Proton beam therapy, except as shown above.*	*All charges*
Physical and occupational therapies	**Standard**
Services rendered by one of the following: • Qualified physical therapist • Occupational therapist Note: We only cover therapy when a provider: • orders the care; • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed. Note: Outpatient physical and occupational therapy requires preauthorization from your provider after 10 visits. See page 19. Note: Vision therapy services require preauthorization. See page 19. Note: Inpatient therapy coverage is limited to 40 days per calendar year for all therapy types combined and requires preauthorization. See page 19. Note: For information on the mental health ABA benefits, see Section 5(e) *Mental Health and Substance Use Disorder Benefits* on page 53.	$35 per office visit $35 per outpatient visit 15% of the allowed amount after deductible per visit during covered inpatient admission

Physical and occupational therapies - continued on next page

Benefit Description	You Pay
Physical and occupational therapies (cont.)	**Standard**
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Services for functional nervous disorders*	*All charges*
Speech therapy	**Standard**
Speech therapy visits Note: We only cover therapy when a provider: • Orders the care; • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the length of time the services are needed. Note: Outpatient speech therapy requires preauthorization from your provider after 10 visits. See page 19. Note: Inpatient therapy coverage is limited to 40 days per calendar year for all therapy types combined. See page 19. Note: For information on the mental health ABA benefits, see Section 5 (e) *Mental Health and Substance Use Disorder Benefits* on page 53.	$35 per office visit $35 per outpatient visit 15% of the allowed amount after deductible per visit during covered inpatient admission
Hearing services (testing, treatment, and supplies)	**Standard**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.* Note: For coverage of external hearing aids and implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants, see Section 5(a) Orthopedic and prosthetic devices.	$15 per office visit to a primary care provider $35 per office visit to a specialist Nothing for preventive visit Nothing for minor diagnostic tests 15% of the allowed amount after deductible for major diagnostic tests
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**Standard**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refractions Note: See *Preventive care, children* for eye exams for children.	$15 per office visit to a primary care physician $35 per office visit to a specialist Nothing for preventive visits 15% of the allowed amount after deductible for covered vision aids
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics*	*All charges*

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You Pay
Vision services (testing, treatment, and supplies) (cont.)	**Standard**
• *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**Standard**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$15 per office visit to a primary care physician $35 per office visit to a specialist
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	**Standard**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Orthotics and other corrective appliances for the foot are covered if part of a lower foot brace and they are prescribed as part of a specific treatment associated with recent, related surgery • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy Note: Artificial limbs (prosthetics) require preauthorization from your physician. See page 19. Note: TMJ coverage is limited to $2,000 per person per calendar year. Note: We will only cover cochlear implants, BAHA and related services and supplies that we determine are medically necessary. We only cover these services when we preauthorize the treatment. See page 19. Note: For information on the professional charges for the surgery to insert the implant, see Section 5(b) *Surgical procedures*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services Provided by a Hospital or Other Facility, and Ambulance Services.*	15% of the allowed amount after deductible
• External hearing aids for children up to age 22 per calendar year • External hearing aids for adults age 22 and over every 3 calendar years	Any amount over $2,500 after deductible
Not covered: • *Orthotics and other corrective appliances for the foot are not covered unless part of a lower foot brace and they are prescribed as part of a specific treatment associated with recent, related surgery*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay
Orthopedic and prosthetic devices (cont.)	**Standard**
• *Lumbosacralsupports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* Prosthetic replacements provided less than 5 years after the last one we covered	*All charges*
Durable medical equipment (DME)	**Standard**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs (custom or motorized*) • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps* • Wound vac* * Note: These items require preauthorization from your physician. Continuous positive airway pressure (CPAP), bilevel positive airway pressure (BiPAP), and DME items with a purchase price over $5,000 also require preauthorization. See page 19. Note: Call us at 844-345-FEHB as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	15% of the allowed amount after deductible
Not covered: *Batteries are not covered unless when used to power:* • *A wheelchair* • *An insulin pump for treatment of diabetes*	*All charges*
Home health services	**Standard**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications Note: Home health requires preauthorization from your physician. See page 19.	15% of the allowed amount after deductible
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family*	*All charges*

Home health services - continued on next page

Benefit Description	You Pay
Home health services (cont.)	**Standard**
• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*
Chiropractic	**Standard**
Chiropractic coverage is limited to 20 visits per calendar year. • Manipulation of the spine and extremities *Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application* Note: Chiropractic benefits are administered through the American Specialty Health (ASH) network. ASH provides claims adjudication, member service, and appeals services for chiropractic claims. Access to ASH chiropractors is based on medical necessity. Members with questions regarding ASH benefits, eligibility, or participating providers can contact the ASH Member Services department at 800-678-9133. A directory of providers who participate with ASH can be found at www.selecthealth.org/fehb or www.ashcompanies.com.	$35 per visit
Alternative treatments	**Standard**
No benefit	All charges
Educational classes and programs	**Standard**
Coverage is provided for: • Tobacco Cessation programs, including individual, group, phone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat nicotine dependence.	Nothing for 4 Tobacco Cessation counseling sessions per quit attempt and 2 quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence. $15 office visit to a primary care physician $35 office visit to a specialist
• Diabetes self management education • Childhood obesity education • Asthma education	Nothing

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Standard Option: The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). We indicate when the deductible applies. The out of pocket maximum is $5,500 per person ($11,000 per Self Plus One enrollment, or $11,000 per Self and Family enrollment).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES**. Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization and identify which surgeries require preauthorization.

Benefit Description	You Pay
The calendar year deductible applies only when indicated below	
Surgical procedures	**Standard**
A comprehensive range of services, such as: • Operative procedures • Vasectomy • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment for morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices. See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for a pacemaker and surgery benefits for insertion of the pacemaker.	$15 per office visit to a primary care physician for minor surgery $35 per office visit to a specialist for minor surgery 15% of the allowed amount after deductible for major surgery

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	**Standard**
Note: Major surgery is a surgical procedure having one or more of the following characteristics: (A) performed within or upon the contents of the abdominal, pelvic, cranial or thoracic cavities; (B) typically requiring general anesthesia; (C) has a level of difficulty or length of time to perform which constitutes a hazard to life or function of an organ or tissue; or (D) requires the special training to perform. Any surgical procedure not classified as major surgery is considered a minor surgical procedure. Note: Preauthorization is required for some surgical procedures. See page 19 for details on which procedures require preauthorization.	$15 per office visit to a primary care physician for minor surgery $35 per office visit to a specialist for minor surgery 15% of the allowed amount after deductible for major surgery
Tubal ligation	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot (see Foot care)*	*All charges*
Reconstructive surgery	**Standard**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts - Treatment of any physical complications, such as lymphedemas - Breast prostheses and surgical bras and replacements (see Prosthetic devices) • Surgeries related to gender reassignment - Breast implantation/augmentation - Orchiectomy - Penectomy - Vaginoplasty - Clitoroplasty - Labiaplasty - Subcutaneous mastectomy - Hysterectomy - Salpingo-oophorectomy - Vaginectomy - Metoidioplasty - Scrotoplasty - Urethroplasty	15% of the allowed amount after deductible

Reconstructive surgery - continued on next page

Benefit Description	You Pay
Reconstructive surgery (cont.)	**Standard**
- Placement of testicular prostheses - Phalloplasty Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Note: Gender reassignment surgery requires preauthorization from your physician. For questions regarding specific covered surgical procedures, please contact Member Services at 844-345-FEHB. See page 19.	15% of the allowed amount after deductible
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* - *The following gender reassignment procedures: Abdominoplasty, blepharoplasty, brow lift, cheek/malar implants, chin/nose implants, collagen injections, facial bone reconstruction, face lift, forehead lift, calf lift, hair removal/hairplasty including medications that cause hair loss or growth, hair transplantation, lip reduction, liposuction, mastopexy, neck tightening, pectoral implants, reduction thyroid chondroplasty, rhinoplasty, voice modification surgery, & voice therapy/lessons*	*All charges*
Oral and maxillofacial surgery	**Standard**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures • Temporomandibular joint disorders (TMJ) Note: TMJ coverage is limited to $2,000 per person per calendar year.	$15 per office visit to a primary care physician $35 per office visit to a specialist 15% of the allowed amount after deductible for a major office surgery 15% of the allowed amount after deductible for physician's fees
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Benefit Description	You Pay
Organ/tissue transplants	**Standard**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas Note: Organ transplants take place in an inpatient setting and require preauthorization. See page 19. These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) Note: Organ transplants take place in an inpatient setting and require preauthorization. See page 19. **Blood or marrow stem cell transplants** The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy	15% of the allowed amount after deductible for physician's fees

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	**Standard**
- Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors Note: Organ transplants take place in an inpatient setting and require preauthorization. See page 19. **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy	15% of the allowed amount after deductible for physician's fees

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	**Standard**
- Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma Note: Organ transplants take place in an inpatient setting and require preauthorization. See page 19. **These blood or marrow stem cell transplants** are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myelodysplasia/Myelodysplastic Syndromes • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma	15% of the allowed amount after deductible for physician's fees

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	**Standard**
- Aggressive non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosaucoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) Note: Organ transplants take place in an inpatient setting and require preauthorization. See page 19. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	15% of the allowed amount after deductible for physician's fees
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**Standard**
Professional services provided in: • Hospital (inpatient) • Hospital (outpatient) • Skilled nursing facility • Ambulatory surgical center Note: Certain pain management services require preauthorization from your physician. See page 19.	15% of the allowed amount after deductible for physician's fees
Professional services provided in: • Office Note: Certain pain management services require preauthorization from your physician. See page 19.	$15 per office visit to a primary care physician $35 per office visit to a specialist 15% of the allowed amount for a major office surgery

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Standard Option: The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). We indicate when the deductible applies. The out of pocket maximum is $5,500 per person ($11,000 per Self Plus One enrollment, or $11,000 per Self and Family enrollment).
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

Benefit Description	You Pay
The calendar year deductible applies only when indicated below.	
Inpatient Hospital	**Standard**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	15% of the allowed amount after deductible per admission
Maternity and delivery • You do not need to preauthorize your normal delivery. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. All non-routine obstetric admissions and maternity stays longer than 48 hours after a regular delivery and 96 hours after a cesarean delivery require preauthorization from your physician. We will extend your inpatient stay if medically necessary. See page 19. • Deliveries rendered by a non-participating provider (whether inside or outside of the service area) will be denied unless the situation is deemed to be an urgent or emergency situation. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Professional services are covered under Section 5(a) and Section 5(b).	$200 per admission

Inpatient Hospital - continued on next page

Benefit Description	You Pay
Inpatient Hospital (cont.)	**Standard**
Note: Childbirth in any place other than a Hospital or a participating birthing center connected to a Hospital either through a bridge, ramp, or adjacent to the labor and delivery unit is not covered. This includes all Provider and/or Facility charges related to the delivery.	$200 per admission
Other hospital services and supplies, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory test and X-rays • Dressing, splints, cases, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetists services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home Note: Inpatient admissions require preauthorization from your physician. See page 19.	15% of the allowed amount after deductible
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds*	*All charges*
Outpatient hospital or ambulatory surgical center	**Standard**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	15% of the allowed amount after deductible
Not covered: • *Platelet rich plasma or other blood derived therapies for orthopedic procedures.*	*All charges*

Benefit Description	You Pay
Skilled nursing care facility benefits	**Standard**
Skilled nursing is covered up to 60 days per calendar year Skilled nursing is only covered when services cannot be provided adequately through a home health program. Note: All admissions to facilities, including rehabilitation, transitional care, skilled nursing, and all routine hospitalizations require preauthorization from your physician. See page 19.	15% of the allowed amount after deductible per admission
Not covered: • *Custodial care*	*All charges*
Hospice care	**Standard**
Hospice care is supportive care provided on an inpatient or outpatient basis to a terminally ill member not expected to live more than six months. Note: Hospice care requires preauthorization from your physician. See page 19.	15% of the allowed amount after deductible per admission
Not covered: • *Independent nursing, homemaker services, custodial care*	*All charges*
Ambulance	**Standard**
Local professional ambulance service when medically appropriate	15% of the allowed amount after deductible

Section 5(d): Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Standard Option: The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). We indicate when the deductible applies. The out of pocket maximum is $5,500 per person ($11,000 per Self Plus One enrollment, or $11,000 per Self and Family enrollment).
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Urgent care is the treatment of acute and chronic illness and injury. SelectHealth Plan FEHB members have access to urgent care clinics owned by Intermountain Healthcare, such as Intermountain Instacare and Intermountain Kidscare. To find urgent care facilities, call Member Services at 844-345-FEHB, or visit our website at www.selecthealth.org/fehb.

If you have an emergency or need urgent care outside of the service area, participating benefits apply to services you receive in a doctor's office, urgent care facility, or emergency room. In an effort to reduce your medical out-of-pocket expenses incurred while traveling, SelectHealth Plan has made an arrangement with the Multiplan and PHCS networks of healthcare providers and facilities. They have agreed to accept an allowed amount for covered services, which means you will not be responsible for excess charges when using these providers. Always present your ID card when visiting providers or facilities. The logos on the card give you access to these networks. To find Multiplan or PHCS providers and facilities, call Multiplan at 800-678-7427 or visit www.multiplan.com.

Benefit Description	You pay
The calendar year deductible applies only when indicated below.	
Emergency within our service area	**Standard**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$35 Urgent care or Intermountain InstaCare visit
• Emergency care as an outpatient at a hospital, including doctors' services	$15 Intermountain KidsCare visit
Note: If you are admitted inpatient during an emergency room (ER) visit, the ER copay will be waived. Instead, Inpatient Hospital benefits will apply.	$200 per visit Emergency Room Copay after deductible
Note: Intermountain KidsCare Clinics are owned by Intermountain Healthcare, and provide after hours urgent care services for pediatric patients. The clinic does not accept primary care patients.	
Note: The Instacare clinic is an Intermountain Healthcare urgent care clinic for patients of all ages. Also see Section 5(a) for Telehealth urgent care services.	
Not covered: • *Elective care or non-emergency care*	*All charges*

Benefit Description	You pay
Emergency outside our service area	**Standard**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: If you are admitted inpatient during an emergency room (ER) visit, the ER copay will be waived. Instead, Inpatient Hospital benefits will apply. Note: Intermountain KidsCare Clinics are owned by Intermountain Healthcare, and provide after hours urgent care services for pediatric patients. The clinic does not accept primary care patients. Note: The Instacare clinic is an Intermountain Healthcare urgent care clinic for patients of all ages. Also see Section 5(a) for Telehealth urgent care services.	$35 Urgent care or Intermountain InstaCare visit $15 Intermountain KidsCare visit $200 per visit Emergency Room Copay after deductible
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside of the service area*	*All charges*
Ambulance	**Standard**
Professional ambulance service (including air ambulance) when medically appropriate. Note: See Section 5(c) for non-emergency service.	15% of the allowed amount after deductible

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Standard Option: The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). We indicate when the deductible applies. The out of pocket maximum is $5,500 per person ($11,000 per Self Plus One enrollment, or $11,000 per Self and Family enrollment).
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR INPATIENT AND RESIDENTIAL TREATMENT CENTER SERVICES.** Please refer to Section 3 for prior authorization information and to be sure with services require prior authorization.

Benefit Description	You Pay
The calendar year deductible applies only when indicated below.	
Professional services	**Standard**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual, single-family, multi-family, or group therapy visits) • Diagnosis and treatment of alcoholism and drug use, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • ABA therapy Note: Inpatient and residential treatment require preauthorization from your physician. See page 19.	$15 per office visit 15% of the allowed amount after deductible for inpatient or outpatient services

Professional services - continued on next page

Benefit Description	You Pay
Professional services (cont.)	**Standard**
Note: For benefit information on the diagnostic and treatment services as well as ABA-related therapy, see Section 5(a) *Medical Services and Supplies Provided by Physicians and other Health Care Professionals*. See page 29.	$15 per office visit 15% of the allowed amount after deductible for inpatient or outpatient services
Telehealth services are covered in accordance with the SelectHealth Plan medical policy when rendered by a participating provider. (Deductible does not apply to telehealth services)	Nothing (deductible does not apply to telehealth services)
Diagnostics	**Standard**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility Note: Inpatient and residential treatment admissions require preauthorization from your physician. See page 19.	$15 per office visit 15% of the allowed amount after deductible for outpatient
Inpatient hospital or other covered facility	**Standard**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services Note: Inpatient and residential treatment admissions require preauthorization from your physician. See page 19.	15% of the allowed amount after deductible per inpatient admission
Outpatient hospital or other covered facility	**Standard**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$15 per office visit 15% of the allowed amount after deductible for outpatient
Methadone maintenance, associated clinics or services	$15 per office visit to a primary care physician $35 per office visit to a specialist 15% of the allowed amount after deductible for inpatient or outpatient services

Section 5(f): Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the following chart.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Federal law prevents the pharmacy from accepting unused medications.
- Standard Option: The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). We indicate when the deductible applies. The out of pocket maximum is $5,500 per person ($11,000 per Self Plus One enrollment, or $11,000 per Self and Family enrollment).
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME PRESCRIPTION DRUGS.** Please contact Pharmacy Services to identify which prescription drugs require preauthorization.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, or by mail through Intermountain Home Delivery for a maintenance medication. Specialty drug prescriptions must be filled at Intermountain Specialty Pharmacy or a SelectHealth Plan Preferred Specialty Pharmacy. To find a participating pharmacy, call the SelectHealth Plan Pharmacy Department at 844-345-FEHB. To see the drugs covered by your plan, log in to your SelectHealth Plan portal, or visit our website at www.selecthealth.org/fehb.
- **We have a closed formulary.** A closed formulary means all new drugs are reviewed prior to being added to the formulary (a list of covered drugs). A non-formulary drug prescribed by a Plan doctor requires a prior authorization to be covered by the plan. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from the formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug list, call 844-345-FEHB.
- Tier 1 is generic drugs. Tier 2 is preferred brand name drugs. Tier 3 is non-preferred brand name drugs. Tier 4 is for injectable drugs and specialty medications.
- **These are the dispensing limitations.** Except for schedule II controlled substances, refills are allowed after 75 percent of the last refill has been used for a 30-day supply (or greater than 30-day supply), and 50 percent for a 10-day supply. Some exceptions may apply, and the timing of refill limits may be adjusted as market dynamics change. Call Pharmacy Services at 844-345-FEHB for more information. You can also contact your pharmacy to find out if you are able to get a prescription refilled.
- **A generic equivalent will be dispensed if it is available**. If you receive a name brand drug when a Federally-approved generic drug is available, you have to pay the difference in cost between the name brand drug and the generic and the difference is not applied to your catastrophic protection out-of-pocket maximum.
- **Why use generic drugs?** A generic drug is a medication in which the active ingredients, safety, dosage, quality, and strength are identical to that of its brand-name counterpart. Generic drugs are regulated by the U.S. Food and Drug Administration just like brand-name drugs.

Benefits Description	You Pay
The calendar year deductible applies only when indicated below.	
Covered medications and supplies	**Standard**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Growth hormone therapy (GHT) • Insulin • Diabetic supplies: - Disposable needles and syringes for the administration of covered medications - Continuous glucose monitors • Drugs for sexual dysfunction Note: Selected prescription drugs and supplies require preauthorization from your physician as referenced on page 19. Contact SelectHealth Plan for information on a specific drug(s) as requirements may change due to new drugs, therapies, or other factors. Note: Drugs for sexual dysfunction are limited; contact SelectHealth Plan for more details on covered sexual dysfunction drugs. Note: GHT is only covered when a prior authorization has been approved for the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services under *You need prior Plan approval for certain services* on page 19. Note: Preauthorization and deductibles do not apply to Naloxone-based rescue agents. A Tier 1 copay applies for a 30-day or 90-day timeframe.	Prescription Medications Tier 1 $5 Tier 2 $40 after deductible Tier 3 50% of the allowed amount up to a $250 maximum, after deductible Tier 4 30% of the allowed amount after deductible Mail Order Maintenance Medications - 90 day supply Tier 1 $5 Tier 2 $80 after deductible Tier 3 50% of the allowed amount after deductible Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Women's contraceptive drugs and devices: • Generic oral contraceptives on our formulary list • Generic emergency contraception, including OTC when filled with a prescription • Generic injectable contraceptives on our formulary list - five (5) vials per calendar year • Diaphragms - one (1) per calendar year • Generic patch contraception	Nothing

Benefits Description	You Pay
Preventive medications	**Standard**
The following are covered: • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 and 800 mcg • Liquid iron supplements for children age 6 months - 1 year • Vitamin D supplements (prescription strength) (400 and 1000 units) for members 65 or older • Prenatal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 • Statin for adults aged 40-75 years with no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater Note: Preventive Medications with a USPSTF recommendations of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for urgent and/or emergencies out-of-area* • *Fertility drugs* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them except as required by the Affordable Care Act* • *Nonprescription medications medicines* • *Prescriptions dispensed in a provider's office are not covered unless expressly approved by SelectHealth Plan* *Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco and nicotine dependence are covered under the Tobacco Cessation benefit.* See page 40.	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating Benefits with Other Coverage*.
- Standard Option: The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). We indicate when the deductible applies. The out of pocket maximum is $5,500 per person ($11,000 per Self Plus One enrollment, or $11,000 per Self and Family enrollment).
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefits Description	You Pay
The calendar year deductible applies only when indicated below.	
Accidental injury benefit	**Standard**
We cover restorative services and supplies necessary to promptly repair and/or replace sound natural teeth. The need for these services must result from an accidental injury. Note: Major surgery is a surgical procedure having one or more of the following characteristics: (A) performed within or upon the contents of the abdominal, pelvic, cranial or thoracic cavities; (B) typically requiring general anesthesia; (C) has a level of difficulty or length of time to perform which constitutes a hazard to life or function of an organ or tissue; or (D) requires the special training to perform. Any surgical procedure not classified as major surgery is considered a minor surgical procedure.	$15 per office visit to a primary care physician, including minor office surgery $35 per office visit to a specialist, including minor office surgery $35 Urgent care or Intermountain Instacare visit $200 emergency room after deductible 15% of the allowed amount after deductible for a major office surgery 15% of the allowed amount after deductible for physician's fees
Dental benefits	**Standard**
We have no other dental benefits.	All charges

Section 5(h). Wellness and Other Special Features

Special feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claims process (see Section 8).
Member Services extended hours	Representatives are available during extended hours to answer questions and help resolve concerns. To contact Member Services, call 844-345-FEHB weekdays, from 7 a.m. to 8 p.m., and Saturdays, from 9 a.m. to 2 p.m.
SelectHealth Plan Member Advocates®	Whether you need help with behavioral or physical health, Member Advocates can help you find the right care for your needs. They can assist with the following: • Scheduling an appointment, including care for urgent conditions • Finding the closest facility or doctor with the nearest available appointment • Providing information about a doctor such as age, training certifications, and languages spoken • Helping you understand and maximize your benefits To contact Member Advocates, call 800-515-2220 weekdays, from 7 a.m. to 8 p.m., and Saturdays, from 9 a.m. to 2 p.m. To access the online provider directory, visit www.selecthealth.org/fehb.
Out-of-Area child(ren) dependent coverage	Dependent children residing outside the service area can receive participating benefits for covered services when using our MultiPlan and/or Private Healthcare System providers outside of Utah. A Dependent Address Change Form, for any dependent children residing outside the service area, must be filled out and submitted in order to receive this extended coverage. To access this form, please visit www.selecthealth.org/fehb. Otherwise, service access outside the service area is limited to only those services that meet the definition of urgent or emergency care. Federal employees, annuitants, and spousal dependents are not eligible for this extended out-of-area coverage. For the definition of eligible dependent children, please refer to FEHB Facts on page 9.

Special feature	Description
Services for deaf and hearing impaired	Free interpreting services will be provided upon request.
Tobacco Cessation Program	One of the most significant things a person can do to improve overall health is to quit smoking. We offer a free program that can help. Quit for Life® allows participants to progress at their own pace from home. For more information, call 866-784-8454.
Online tools	Our comprehensive package of online tools and resources allows you to search for participating doctors and facilities, find lower-cost medications, and even create a personalized fitness plan. The SelectHealth Plan Portal, our secure member website, allows you to manage your health information in one location. You can access your SelectHealth Plan Portal by logging in at www.selecthealth.org/fehb. Once you have logged in, you can access the following tools: • View your claims by accessing online Explanation of Benefits (EOBs) • Send a secure message to Member Services • View your pharmacy claims, and find participating pharmacies • Improve your health by taking a personal health assessment, tracking your progress, and utilizing other wellness tools • Access medical records, including lab, pathology, and imaging results, from Intermountain providers that use this program. E-mail questions to certain Intermountain providers
Member discounts	Embracing a healthy lifestyle is more convenient when it costs less. As a SelectHealth Plan member, you can access discounts on health-related products such as gym memberships, eyewear, LASIK, spas, and nutrition supplements. You can receive these discounts by simply showing your SelectHealth Plan ID Card. A complete list is available at www.selecthealth.org/discounts.
Working with Intermountain Healthcare	SelectHealth® Plan is a not-for-profit health plan serving more than 800,000 members in Utah and Idaho. For more than 35 years, we've been committed to helping our members and everyone in our communities stay healthy. In fact, we share a mission with Intermountain Healthcare®: *Helping people live the healthiest lives possible.*® Our integration with Intermountain Healthcare helps us ensure high-quality healthcare at the lowest possible cost for our members and the community.
SelectHealth Plan Healthy Beginnings®	Our prenatal program provides support and resources for expectant mothers. Registered nurses work with moms-to-be and their providers through every trimester and question. There's no catch and no cost. In addition to expert care and support, each enrollee receives a kit of education materials. The program encourages the following: • A prenatal exam prior to the 14th week of pregnancy. • A postpartum exam within 50 days of your delivery date. For more information, call Healthy Beginnings at 866-442-5052.

Special feature	Description
Preventive care	The goal of preventive care, such as regular checkups and screenings, is to help you avoid illness and to detect problems when they are most treatable. Your plan covers preventive care 100 percent—that means no deductible, copay or coinsurance. Examples of preventive services include the following: • Certain examinations and/or screenings (for example, a mammogram, colon and prostate cancer screenings, etc.) • Flu and pneumonia vaccinations • Certain screenings laboratory and X-ray tests (such as Pap smears or cholesterol tests) • Routine immunizations Checkups may include tests performed by your doctor to manage a known condition, such as treating high blood pressure to prevent a heart attack or a stroke. Services performed to maintain a known condition are not usually considered preventive. Your regular deductible, copay and/or coinsurance will apply to these services. SelectHealth Plan has always been committed to covering preventive services. However, not every preventive service is appropriate every year, and recommended screening guidelines may vary. We offer online resources that give you access to immunization schedules, tips for women's health, and information about preventive care exams and tests. You may also complete a personal health assessment and take quizzes about exercise and nutrition. To encourage you to schedule a preventive care appointment, we have an interactive phone system that delivers education. These calls give you the option to have one of our Member Advocates call you back to help you find a doctor.
Care Management	Trained registered nurse care managers are available to assist you with various health concerns and can help coordinate services between providers and patients. Our Care Management Programs offer educational materials, newsletters, follow-up phone calls, and additional support. Care Management covers these areas: • Allergies and rhinitis • Asthma • Cancer • Chronic obstructive pulmonary disease (COPD) • Depression • Diabetes • Heart disease • High-risk pregnancy • Migraines For more information, call Care Management at 800-442-5305.
Healthy Living℠	Participate in the Healthy Living program to improve your health. Complete a biometric screening and an online health assessment (through your SelectHealth Plan Portal) and receive an individualized health report. This can help you identify and address health risks. This information will not be shared with your employer. You can access your SelectHealth Plan Portal by logging in at www.selecthealth.org/fehb.

Special feature	Description
Intermountain Connect Care℠	Healthcare on your schedule - no lines, no waiting room. Intermountain Connect Care is a convenient way to talk to a provider about urgent medical issues, no appointment necessary. So don't suffer on vacation or wait when other options aren't available: Use your smartphone, tablet, or computer to connect to a provider within minutes. Download the app or visit www.intermountainconnectcare.org to get started. The providers at Connect Care can help you with: • Cough • Ear pain • Eye infection • Joint pain/strain • Lower back pain • Minor burns/rashes/skin infections • Sinus pain/pressure • Seasonal allergies • Sore throat • Urinary pain To save time, create a Connect Care account now so it will be ready when you need it. Your information will be stored securely for future visits.
Intermountain Health Answers	A phone call could save you money - and an ER visit. Instead of relying on the Internet for self-diagnosis, our members can pick up the phone and talk to a registered nurse at any time. This 24/7 service is available through Intermountain Health Answers, which is staffed by registered nurses and offered exclusively to our members and the uninsured. Using nationally standardized protocols, these nurses offer home-based remedies and make recommendations for when to seek care from a provider, urgent care clinic, or ER. Intermountain Health Answers is free and can help you make sense of your symptoms and determine how and where to get the best care. To reach Health Answers, you can call 844-501-6600.
Travel benefit/services overseas	If you are traveling outside of the country and need urgent or emergency care, visit the nearest doctor or hospital. Notify us of your circumstances as soon as possible. You may be required to pay for treatment at the time of service and then submit an itemized statement or claim to SelectHealth Plan. All services obtained outside of the United States unless routine, urgent or emergency condition require preauthorization. See page 19. Our Care Management team may become involved to help with any out-of-country health issues or claims that are particularly complicated. If you are outside of the SelectHealth Plan service area (more than 40 miles away from a participating provider or facility), participating benefits apply to services for urgent or emergency conditions rendered in any doctor’s office or any urgent care facility.
Intermountain Weight Management Program	Finding a balance of fitness and nutrition that works for your body is important for a lasting weight management program. The Intermountain Weight Management program is for overweight adults and children who want to lose weight, improve their health, and feel better every day. This program works because: • **It's personal.** You choose the classes that will help you learn the skills and knowledge you need. • **It's professional**. The program is led by registered dietitians with training and experience in weight management. Guest lectures are taught by professionals with other areas of expertise.

	• **It's proven**. The program is based on the latest evidence about what works for weight loss and for making changes that last a lifetime. SelectHealth Plan will cover the cost of the program once per calendar year for eligible members who complete all course requirements. Contact SelectHealth Plan at 844-345-FEHB to verify your coverage.
SelectHealth Plan Mobile App	If you've got your phone, we've got you covered. With the SelectHealth® Plan mobile app, you have access to your health plan whenever - and wherever - you need it. Access your insurance plan on the go. With our secure app, you can: • View, email, and fax images of your ID card • Search for doctors and hospitals • View your benefits and claims, including year-to-date totals • Look up pharmacies and medications Find us on Google Play® and the Apple® App Store.SM
Wellness incentive	Participate in the FEHB wellness incentive program to improve your health and earn an incentive. Eligible members must be age 18 or older and enrolled on a SelectHealth Plan FEHB plan option. Log in to the SelectHealth Plan Portal at www.selecthealth.org/fehb to access the health risk assessment. Receive up to a combined total of either $75 per person or $200 per family for completion of qualified wellness events. Contact Member Services at 844-345-FEHB or visit www.selecthealth.org/fehb for more information.

High Deductible Health Plan Benefits

See page 17 for how our benefits changed this year and page 130 for a benefits summary. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the general exclusions in Section 6, they apply to benefits in the following subsections. To obtain claim forms, claim filing advice, or more information about HDHP benefits, contact us at 844-345-FEHB or on our website at www.selecthealth.org/fehb.

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The plan gives you greater control over how you use your health care benefits.

When you enroll in this HDHP, we establish a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available all at once.

With this plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the plan's deductible before we pay benefits according to the benefits described on page 77. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care** — The plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 100% if you use a network provider and the services are described in Section 5 *Preventive Care*. You do not have to meet the deductible before using these services.
- **Traditional medical coverage** — After you have paid the plan's deductible, we pay benefits under traditional medical coverage described in Section 5.

  Covered services include:

  - Medical services and supplies provided by physicians and other health care professionals
  - Surgical and anesthesia services provided by physicians and other health care professionals
  - Hospital services, other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance use disorder benefits
  - Prescription drug benefits
  - Dental benefits
- **Savings** — Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 69 for more details).

Health Savings Accounts (HSAs)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits within the last three months or do not have other health insurance coverage other than another High Deductible Health Plan.

In 2021, for each month you are eligible for premium pass through, we will contribute $75 per month or $900 annually for Self Only enrollment or $150 per month or $1,800 annually for Self Plus One enrollment or $150 per month or $1,800 annually for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $3,600 for an individual and $7,200 for a family. See maximum contribution information on page 69.

You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

https://www.opm.gov/healthcare-insurance/healthcare/health-savings-accounts/frequently-asked-questions/

HSA features include:

- Your HSA is administered by HealthEquity
  - For questions regarding your HSA administered by HealthEquity, call 866-346-5800 or visit www.healthequity.com
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It is portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA) and start or become covered by a HCFSA health care flexible spending account (such as FSAFEDS offers - see Section 11), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

Health Reimbursement Arrangements (HRAs)

If you are not eligible for an HSA, for example, you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. **You must notify us that you are ineligible for an HSA.**

In 2021, we will give you an HRA credit of $900 per year for a Self Only enrollment or $1,800 per year for a Self Plus One enrollment or $1,800 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that do not count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by HealthEquity
  - If you have questions regarding your HRA administered by HealthEquity, call 866-346-5800 or visit www.healthequity.com
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available at the beginning of your enrollment period
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA); however, you must meet FSAFEDS eligibility requirements

Catastrophic protection for out-of-pocket expenses

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $5,000 per person or $10,000 per Self Plus One enrollment or, $10,000 Self and Family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

Health education resources and account management tools

Access education resources and tools are available at www.selecthealth.org/fehb and www.healthequity.com.

Wellness incentive

Participate in the FEHB wellness incentive program to improve your health and earn an incentive. Eligible members must be age 18 or older and enrolled on a SelectHealth Plan FEHB plan option. Log in to the SelectHealth Plan Portal at www.selecthealth.org/fehb to access the health risk assessment.

Receive up to a combined total of either $75 per person or $200 per family for completion of qualified wellness events. Contact Member Services at 844-345-FEHB or visit www.selecthealth.org/fehb for more information.

Section 5. Savings - HSAs and HRAs

Feature comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with HealthEquity. HealthEquity is the non-bank custodian and preferred HSA administrator for this Plan. HealthEquity has a relationship with Charles Schwab Bank to manage the investment options for members with an HSA. Members can contact HealthEquity directly for assistance at 866-346-5800.	SelectHealth Plan is the HRA fiduciary for this Plan. HealthEquity is the HRA administrator for this Plan. Members can contact HealthEquity directly for assistance at 866-346-5800.
Fee	Set-up fee is paid by the Plan. No administrative fee is charged by the Plan.	A HealthEquity set-up fee of $20.00 is charged when you fail to notify SelectHealth Plan within 30 days of enrollment that an HRA is needed instead of an HSA.
Eligibility	You must: • Enroll in this HDHP • Not be enrolled in another health plan that is not eligible to be paired with an HSA (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare Part A or Part B • Not be claimed as a dependent on someone else's tax return • Not have received VA (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits in the last three months	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. If your eligibility date is **after** the first of the month, your HSA account will be established and funded the beginning of the following month. A debit card will be issued to you at the time of enrollment and can be used to pay for eligible medical expenses.	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you at the beginning of your enrollment period.
• **Self Only enrollment**	For 2021, a monthly premium pass through of $75.00 will be made by the HDHP directly into your HSA each month.	For 2021, your HRA annual credit is $900 (prorated for mid-year enrollment).

• **Self Plus One enrollment**	For 2021, a monthly premium pass through of $150.00 will be made by the HDHP directly into your HSA each month.	For 2021, your HRA annual credit is $1,800 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2021, a monthly premium pass through of $150.00 will be made by the HDHP directly into your HSA each month.	For 2021, your HRA annual credit is $1,800 (prorated for mid-year enrollment).
Contributions/ credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,600 for an individual and $7,200 for a family in 2021. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Catch-up contribution discussed on page 72.	The full HRA credit will be available, subject to proration, at the beginning of your enrollment period. The HRA does not earn interest.
• **Self Only enrollment**	You may make an annual maximum contribution of $2,750.	You cannot contribute to the HRA.
• **Self Plus One enrollment**	You may make an annual maximum contribution of $5,500.	You cannot contribute to the HRA.

• **Self and Family enrollment**	You may make an annual maximum contribution of $5,500.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • Debit card • Withdrawal form • Checks • Electronic funds transfer	For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as dental services, a reimbursement form will be sent to you upon your request. A debit card issued to you at the time of enrollment can be used to pay for eligible medical expenses (see IRS Publication 502). Claim payments made by HealthEquity on behalf of an HDHP enrollee may have to be validated by the enrollee, prior to HRA reimbursement.
Distributions/ withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. Your HSA is established the first of the month following the effective date of your enrollment in this HDHP. For most Federal enrollees (those not paid on a monthly basis), the HDHP becomes effective the first pay period in January 2021. If the HDHP is effective on a date other than the first of the month, the earliest date medical expenses will be allowable is the first of the next month. If you were covered under an HDHP in 2020 and remain enrolled in an HDHP, your medical expenses incurred January 1, 2021 or later, will be allowable. See IRS Publication 502 for a list of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. You must submit these expenses with a claim form for reimbursement (available within your HealthEquity web portal). See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 for a list of eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable - distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change).	Funds are available at the beginning of your enrollment period. • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change); and

	• The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish.	• The HDHP receives record of your enrollment and you notify SelectHealth Plan of the need to establish an HRA on your behalf. • A HealthEquity set-up fee of $20.00 is charged when you fail to notify SelectHealth Plan within 30 days of enrollment that an HRA is needed instead of an HSA.
Account owner	FEHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 69 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions**

  All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season and your effective date is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Catch-up contributions**

  If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury website at www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx.

- **If you die**

  If you have not named a beneficiary and you are married, your HSA becomes your spouse's; otherwise, your HSA becomes part of your taxable estate.

- **Qualified expenses**

  You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, **physician prescribed** over-the-counter drugs, LASIK surgery, and some nursing services.

When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 800-829-3676, or visit the IRS website at www.irs.gov and click on "Forms and Publications." Note: Although **physician prescribed** over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses** — You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- **Tracking your HSA balance** — You will receive periodic notification(s) that shows the "premium pass through", withdrawals, and interest earned on your account. Additionally, you will receive notification when you withdraw money from your HSA.
- **Minimum reimbursements from your HSA** — You can request reimbursement up to the account balance of your HSA.

If you have an HRA

- **Why an HRA is established** — If you do not qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you.

  If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you are ineligible for an HSA or become ineligible to contribute to an HSA.

  A HealthEquity set-up fee of $20.00 is charged when you fail to notify SelectHealth Plan within 30 days of enrollment that an HRA is needed instead of an HSA.
- **How an HRA differs** — Please review the chart on page 69 which details the differences between an HRA and an HSA. The major differences are:
  - You cannot make contribution to an HRA
  - Funds are forfeited if you leave the HDHP
  - An HRA does not earn interest
  - HRAs can only pay for qualified medical expense, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Section 5. Preventive Care

Important things you should keep in mind about these benefits:

- Plan physicians must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider.
- Preventive care is health care services designed for prevention and early detection of illness in average risk, people without symptoms, generally including routine physical examinations, tests and immunizations. We follow the U.S. Preventive Task Force recommendations for preventive care unless noted otherwise.
- Preventive care services listed in this section are not subject to the deductible. The Plan pays 100% for these preventive care services.
- Preventive care rendered by an out-of-network provider will not be covered.
- For all other covered expenses, please see Section 5 - *Traditional Medical Coverage Subject to the Deductible*.
- All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **YOUR PHYSICIAN MUST OBTAIN PRIOR AUTHORIZATION FOR CERTAIN SERVICES, SUPPLIES, AND DRUGS.** Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You Pay
Preventive care, adult	
Professional services, such as: • Routine physicals • Routine screenings • Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) • Routine prenatal care • Tobacco cessation programs • Obesity weight loss programs • Disease management programs	Nothing
Routine physical once every year The following preventive services are covered at the time interval recommended at each of the links below. • Immunizations such as Pneumococcal, influenza, shingles, tetanus/ DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Individual counseling on prevention and reducing health risks	Nothing

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	
• Well woman care such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Woman preventive care services please visit the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/	Nothing
Routine mammogram - covered for women	Nothing
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule.	Nothing
• Routine exams limited to: - One routine eye exam every 12 months - One routine hearing exam every 12 months	Nothing
Nutritional therapy Note: Medical nutritional therapy is a comprehensive nutrition service provided by dietitians with a state license or statutory certification. Note: After the 5th visit, nutritional therapy is covered under the impatient, outpatient, or office visit benefit, depending on where the therapy is rendered. For questions regarding specific medical benefits, please contact Member Services at 844-345-FEHB.	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html Women's preventive services: healthcare.gov/preventive-care-women/	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*

Benefit Description	You Pay
Preventive care, children	
Well-child visits examinations and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics	Nothing
Nutritional therapy Note: Medical nutritional therapy is a comprehensive nutrition service provided by dietitians with a state license or statutory certification. Note: After the 5th visit, nutritional therapy is covered under the inpatient, outpatient, or office visit benefit, depending on where the therapy is rendered. For questions regarding specific medical benefits, please contact Member Services at 844-345-FEHB.	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments and coinsurance. Note: A complete list of preventive care services recommended under the U.S. Preventive Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html For additional information: www.healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*

Section 5. Traditional Medical Coverage Subject to the Deductible

Important things you should keep in mind about these benefits:

- Traditional medical coverage does not begin to pay until you have satisfied your deductible.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider. You must use Plan facilities. You are responsible for verifying that your provider has arranged for your surgery or hospitalization in a Plan facility. We will not pay for services provided by a non-Plan provider or facility without our prior authorization.
- The deductible is $1,500 per person ($3,000 per Self Plus One enrollment, or $3,000 per Self and Family enrollment). The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total $5,000 per person, $10,000 per Self Plus One enrollment or $10,000 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR PHYSICIAN MUST OBTAIN PRIOR AUTHORIZATION FOR SOME SERVICES, SUPPLIES, AND DRUGS.** Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You Pay After the calendar year deductible
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. In the **You Pay** column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of $1,500 per person, $3,000 per Self Plus One enrollment or $3,000 per Self and Family enrollment.
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is $1,500 for Self Only enrollment, $3,000 per Self Plus One enrollment, or $3,000 for a Self and Family enrollment) each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay After the calendar year deductible...
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion • Advanced care planning • Home visits	$10 per office visit to a primary care physician $30 per office visit to a specialist
• In an urgent care center Note: The Instacare clinic is an Intermountain Healthcare urgent care clinic for patients of all ages. Note: KidsCare clinics are owned by Intermountain Healthcare and provide after-hours urgent care services for pediatric patients. The clinic does not accept primary care patients.	$30 Urgent care or Intermountain Instacare visit $10 Intermountain KidsCare visit
• During a hospital stay • In a skilled nursing facility • Private duty nursing Note: Private duty nursing requires preauthorization from your Physician. See page 19.	Nothing $150 for outpatient facility services $150 per day up to $750 per admission for inpatient facility services
Applied behavior analysis (ABA) Office visit services performed by a board-certified physician in neurology or pediatrics with experience in diagnosing autism spectrum disorder: • Evaluation, management, and assessment services necessary to determine whether a member has an autism spectrum diagnosis	$10 per office visit to a primary care physician $30 per office visit to a specialist

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Diagnostic and treatment services (cont.)	
Behavior training, management, and ABA therapy services by certified therapists: • Care rendered in the home or other clinical setting Note: For information on physical/occupational/speech therapy benefits, see page 84. For information on the mental health ABA benefits, see Section 5(e) *Mental Health and Substance Use Benefits.*	$10 per office visit to a primary care physician $30 per office visit to a specialist
Telehealth Services	
Urgent Care/Intermountain Connect Care telehealth services – Intermountain Connect Care is a convenient way to talk to a provider about urgent medical issues, no appointment necessary. Use your smartphone, tablet, or computer to connect to a provider within minutes. Download the app or visit www.intermountainconnectcare.org to get started. Provider at Connect Care can help you with: • Cough • Ear pain • Eye infection • Joint pain/strain • Lower back pain • Minor burns/rashes/skin infections • Sinus pain/pressure • Seasonal allergies • Sore throat • Urinary pain	Nothing, Deductible waiver applies to telehealth services
All non-urgent telehealth services – Telehealth services are covered in accordance with the SelectHealth Plan medical policy when rendered by a participating provider. (Deductible does not apply to telehealth services)	Nothing, Deductible waiver applies to telehealth services
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing for minor diagnostic tests $150 for major diagnostic tests

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Lab, X-ray and other diagnostic tests (cont.)	
Note: Preauthorization is required for certain diagnostic testing. See page 19. Note: Major and minor diagnostic tests are based on several considerations such as the invasiveness and complexity of the test, the level of expertise required to interpret or perform the test, and where the test is commonly performed. If you have a question about the category of a particular test, please contact Member Services at 844-345-FEHB.	Nothing for minor diagnostic tests $150 for major diagnostic tests
Injectable drugs (medical)	
Injectable, implantable, and IV therapy drugs rendered in a provider's office or in a facility setting. Note: Preauthorization is required for certain injectable drugs and specialty medications (even when Medicare is your primary insurance). See 19. If you have questions about preauthorization requirements, please call Member Services at 844-345-FEHB.	30% of the allowed amount
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care	A single office visit copay of $20 when pregnancy is confirmed; nothing for subsequent prenatal or postpartum care.
Screening for gestational diabetes for pregnant women	Nothing
Breastfeeding support, supplies and counseling for each birth	Nothing
Note: Here are some things to keep in mind: • You do not need to preauthorize your vaginal or cesarean delivery; see page 19 for other circumstances, such as extended stays for you or your baby. • Deliveries rendered by a non-participating provider (whether inside or outside of the service area) will be denied unless the situation is deemed to be an urgent or emergency situation. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. All non-routine obstetric admissions and maternity stays longer than 48 hours after a vaginal delivery and 96 hours after a cesarean delivery require preauthorization from your physician. We will extend your inpatient stay if medically necessary. See page 19. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b).	

Maternity care - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Maternity care (cont.)	
Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. Note: Childbirth in any place other than a Hospital or a participating birthing center connected to a Hospital either through a bridge, ramp, or adjacent to the labor and delivery unit is not covered. This includes all Provider and/or Facility charges related to the delivery.	
Not covered: • *Home delivery*	*All charges*
Family planning	
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: • Tubal ligation. See Section 5(b) *Surgical procedures* on page 89. • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit. Vasectomies, see Section 5(b) on page 104.	Nothing
Genetic testing: • Prenatal testing when performed as part of an amniocentesis to assess specific chromosomal abnormalities in women at high risk for inheritable conditions that can lead to significant immediate and/or long-term health consequences to the child after birth: • Neonatal testing for specific inheritable metabolic conditions (e.g. PKU) • When the member has more than five-percent probability of having an inheritable genetic condition and has signs or symptoms suggestive of a specific condition or a strong family history of the condition (defined as two or more first-degree relatives with the condition) and results of the testing will directly affect the patient's treatment • Pre-implantation embryonic genetic testing performed to identify an inherited genetic condition known to already exist in either parent's family which has the potential to cause serious and impactful medical conditions for the child Note: Gene therapy and genetic testing requires preauthorization from your physician. See page 19. Note: Genetic counseling is covered when provided by a participating provider.	Nothing for professional fees $150 copay
BRCA testing	Nothing

Family planning - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Family planning (cont.)	
Note: BRCA testing requires preauthorization from your physician. See page 19.	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling services not shown as covered*	*All charges*
Infertility services	
Infertility is a condition resulting from a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. Services for the diagnosis of infertility are only covered in limited circumstances, including fulguration of ova ducts, hysteroscopy, hysterosalpingogram, certain laboratory tests, diagnostic laparoscopy, and some imaging studies. For a full list of covered infertility services, please contact SelectHealth Plan. Note: Infertility does not apply to the out-of-pocket maximum. Infertility coverage is limited to a maximum plan payment of $1,500 per calendar year.	50% of allowed amount
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *Artificial insemination (AI), such as:* • *Intravaginal insemination (IVI)* • *Intracervical insemination (ICI)* • *Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Oncofertility* • *Fertility drugs*	*All charges*
Allergy care	
• Testing	$10 per office visit to a primary care physician for testing $30 per office visit to a specialist for testing
• Allergy treatment • Allergy injections • Allergy serum	$100 copay
Not covered:	*All charges*

Allergy care - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Allergy care (cont.)	
• *Certain allergy tests and treatment are not covered. Contact SelectHealth Plan Member Services for details.*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: Certain radiation therapies and medical oncology drugs require preauthorization. See page 19. Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b) on page 91. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy Note: Enteral formula requires preauthorization from your physician. See page 19. • Growth hormone therapy (GHT) Note: Growth hormone therapy is covered under the prescription drug benefit and requires preauthorization. See page 19 and Section 5(f) *Prescription Drug Benefits* on page 104. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services under *You need prior Plan approval for certain services* on page 19. • Applied behavior analysis (ABA) - Children with autism spectrum disorder Note: For information on the mental health ABA benefits, see Section 5 (e) Mental Health and Substance Use Disorder Benefits. See page 101.	$150 per day
Cardiac rehabilitation following qualifying event/condition	Nothing
Proton beam therapy in the following limited circumstances: • Chordomas or chondrosarcomas arising at the base of the skull or along the axial skeleton without distant metastases; • Other central nervous system tumors located near vital structures; • Pituitaryneoplasms; • Uveal melanomas confined to the globe (not distant metastases); or • In accordance with SelectHealth Plan medical policy	$150 per day

Treatment therapies - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Treatment therapies (cont.)	
Not covered: • *Neutron beam therapy* • *Proton beam therapy, except as shown above*	*All charges*
Physical and occupational therapies	
Services rendered by one of the following: • Qualified physical therapist • Occupational therapist Note: We only cover therapy when a provider: • orders the care; • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed. Note: Outpatient physical and occupational therapy require preauthorization from your provider after 10 visits. See page 19. Note: Vision therapy services require preauthorization. See page 19. Note: Inpatient therapy coverage is limited to 40 days per calendar year for all therapy types combined. Note: For information on the mental health ABA benefits, see Section 5 (e) *Mental Health and Substance Use Disorder Benefits*. See page 101.	$30 per office visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Services for functional nervous disorders*	*All charges*
Speech therapy	
Speech therapy visits Note: We only cover therapy when a provider: • orders the care; • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed. Note: Outpatient speech therapy requires preauthorization from your provider after 10 visits. See page 19. Note: Inpatient therapy coverage is limited to 40 days per calendar year for all therapy types combined. Note: For information on the mental health ABA benefits, see Section 5 (e) *Mental Health and Substance Use Disorder Benefits*. See page 101.	$30 per office visit

Benefit Description	You Pay After the calendar year deductible...
Hearing services (testing, treatment, and supplies)	
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.* Note: For coverage of external hearing aids and implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants, see Section 5(a) *Orthopedic and prosthetic devices.*	$10 per office visit to a primary care physician $30 per office visit to a specialist Nothing for preventive visits
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refractions Note: See *Preventive care, children* for eye exams for children.	$10 per office visit to a primary care physician $30 per office visit to a specialist Nothing for preventive visits
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$10 per office visit to a primary care physician $30 per office visit to a specialist
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Orthotics and other corrective appliances for the foot are covered if part of a lower foot brace and they are prescribed as part of a specific treatment associated with recent, related surgery	Nothing for professional fees

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Orthopedic and prosthetic devices (cont.)	
• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy Note: Artificial limbs (prosthetics) require preauthorization from your physician. See page 19. Note: TMJ coverage is limited to $2,000 per person per calendar year. Note: We will only cover cochlear implants, BAHA and related services and supplies that we determine are medically necessary. We only cover these services when we preauthorize the treatment. See page 19. Note: For information on the professional charges for the surgery to insert the implant, see Section 5(b) *Surgical procedures*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c) *Services Provided by a Hospital or Other Facility, and Ambulance Services*.	Nothing for professional fees
• External hearing aids for children up to age 22 per calendar year • External hearing aids for adults age 22 and over every 3 calendar years	Any amount over $2,500
Not covered: • *Orthotics and other corrective appliances for the foot are not covered unless part of a lower foot brace and they are prescribed as part of a specific treatment associated with recent, related surgery* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 5 years after the last one we covered*	*All charges*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs (custom or motorized*) • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps* • Wound vac*	Nothing for professional fees 5% of the allowed amount

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	
* Note: These items require preauthorization from your physician. Continuous positive airway pressure (CPAP), bilevel positive airway pressure (BiPAP), and DME items with a purchase price over $5,000 also require preauthorization. See page 19. Note: Call us at 844-345-FEHB as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	Nothing for professional fees 5% of the allowed amount
Not covered: *Batteries are not covered unless when used to power:* • *A wheelchair* • *An insulin pump for treatment of diabetes*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications Note: Home health requires preauthorization from your physician. See page 19.	$150 per day
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*
Chiropractic	
Chiropractic coverage is limited to 20 office visits per calendar year. • Manipulation of the spine and extremities *Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application* Note: Chiropractic benefits are administered through the American Specialty Health (ASH) network. ASH provides claims adjudication, member service, and appeals services for chiropractic claims. Access to ASH chiropractors is based on medical necessity. Members with questions regarding ASH benefits, eligibility, or participating providers can contact ASH Member Services at 800-678-9133. A directory of providers who participate with ASH can be found at www.selecthealth.org/fehb or www.ashcompanies.com.	$30 per office visit

Benefit Description	You Pay After the calendar year deductible...
Alternative treatments	
No benefit	All charges
Educational classes and programs	
Coverage is provided for: • Tobacco cessation programs, including individual, group, phone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat nicotine dependence.	Nothing for 4 tobacco cessation counseling sessions per quit attempt and 2 quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
• Diabetes self management education • Childhood obesity education • Asthma education	Nothing

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. It is your responsibility to verify that your physician has scheduled your surgery in a Plan facility. We will not pay for services provided by a non-Plan provider or facility without our prior authorization.
- The deductible is $1,500 for Self Only enrollment, $3,000 per Self Plus One enrollment, and $3,000 Self and Family enrollment each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES**. Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization and identify which surgeries require preauthorization.

Benefits Description	You Pay After the calendar year deductible...
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment for morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices. See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for a pacemaker and surgery benefits for insertion of the pacemaker. Note: Preauthorization is required for some surgical procedures. See page 19 for details on which procedures require preauthorization.	Nothing
Vasectomy	Professional fees: Nothing

Surgical procedures - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Surgical procedures (cont.)	
	Inpatient facility: $150 per day up to $750 per admission Outpatient facility: $150 copay
Tubal ligation	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot (see Foot care)*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts - Treatment of any physical complications, such as lymphedemas - Breast prostheses and surgical bras and replacements (see *Prosthetic devices*) • Surgeries related to gender reassignment - Breast implantation/augmentation - Orchiectomy - Penectomy - Vaginoplasty - Clitoroplasty - Labiaplasty - Subcutaneous mastectomy - Hysterectomy - Salpingo-oophorectomy - Vaginectomy - Metoidioplasty - Scrotoplasty - Urethroplasty - Placement of testicular prostheses - Phalloplasty	Nothing

Reconstructive surgery - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Reconstructive surgery (cont.)	
Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Note: Gender reassignment surgery requires preauthorization from your physician. See page 19. For questions regarding specific covered surgical procedures, please contact Member Services at 844-345-FEHB.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* - *The following gender reassignment procedures: abdominoplasty, blepharoplasty, brow lift, cheek/malar implants, chin/nose implants, collagen injections, facial bone reconstruction, face lift, forehead lift, calf lift, hair removal/hairplasty including medications that cause hair loss or growth, hair transplantation, lip reduction, liposuction, mastopexy, neck tightening, pectoral implants, reduction thyroid chondroplasty, rhinoplasty, voice modification surgery, & voice therapy/lessons*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures • Temporomandibular joint disorders (TMJ) Note: TMJ coverage is limited to $2,000 per person per calendar year.	$10 per office visit to a primary care physician $30 per office visit to a specialist
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung	Nothing

Organ/tissue transplants - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
• Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas Note: Organ transplants take place in an inpatient setting and require preauthorization. See page 19. These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) Note: Organ transplants take place in an inpatient setting and require preauthorization. See page 19. **Blood or marrow stem cell transplants** The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)	Nothing

Organ/tissue transplants - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
- Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors Note: Organ transplants take place in an inpatient setting and require preauthorization. See page 19. **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency	Nothing

Organ/tissue transplants - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
- Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma Note: Organ transplants take place in an inpatient setting and require preauthorization. See page 19. **These blood or marrow stem cell transplants** are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myelodysplasia/Myelodysplastic Syndromes • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Aggressive non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosaucoma	Nothing

Organ/tissue transplants - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
- Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) Note: Organ transplants take place in an inpatient setting and require preauthorization. See page 19. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital (outpatient) • Skilled nursing facility • Ambulatory surgical center Note: Certain pain management services require preauthorization from your physician. See page 19.	Nothing
Professional services provided in: • Office Note: Certain pain management services require preauthorization from your physician. See page 19.	$10 per office visit to a primary care physician $30 per office visit to a specialist

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The deductible is $1,500 for Self Only enrollment, $3,000 per Self Plus One enrollment and $3,000 per Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional fees (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$150 per day up to $750 per admission
Maternity and delivery • You do not need to preauthorize your normal delivery. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. All non-routine obstetric admissions and maternity stays longer than 48 hours after a regular delivery and 96 hours after a cesarean delivery require preauthorization from your physician. We will extend your inpatient stay if medically necessary. See page 19. • Deliveries rendered by a non-participating provider (whether inside or outside of the service area) will be denied unless the situation is deemed to be an urgent or emergency situation. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	$100 per admission

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	
• Professional services are covered under both Sections 5(a) and 5(b). Note: Childbirth in any place other than a Hospital or a participating birthing center connected to a Hospital either through a bridge, ramp, or adjacent to the labor and delivery unit is not covered. This includes all Provider and/or Facility charges related to the delivery.	$100 per admission
Other hospital services and supplies, such as: • Operating, recovery and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory test and X-rays • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressing, splints, cases, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetists services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home Note: Inpatient admissions require preauthorization from your physician. See page 19.	$150 per day up to $750 per admission
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$150 per day
Not covered:	*All charges*

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Outpatient hospital or ambulatory surgical center (cont.)	
• *Platelet rich plasma or other blood derived therapies for orthopedic procedures.*	*All charges*
Skilled nursing care facility benefits	
Skilled nursing is covered up to 60 days per calendar year Skilled nursing is only covered when services cannot be provided adequately through a home health program. Note: All admissions to facilities, including rehabilitation, transitional care, skilled nursing, and all routine hospitalizations require preauthorization from your physician. See page 19.	$150 per day up to $750 per admission
Not covered: • *Custodial care*	*All charges*
Hospice care	
Hospice care is supportive care provided on an inpatient or outpatient basis to a terminally ill member not expected to live more than six months. Note: Hospice care requires preauthorization from your physician. See page 19.	$150 per day for outpatient facility services $150 per day up to $750 per admission for inpatient facility services
Not covered: • *Independent nursing, homemaker services*	*All charges*
Ambulance	
Local professional ambulance service when medically appropriate	$100 copay

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $1,500 for Self Only enrollment, $3,000 per Self Plus One enrollment and $3,000 per Self and Family enrollment each calendar year. The Self and Family and Self Plus One deductibles can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Urgent care is the treatment of acute and chronic illness and injury. SelectHealth Plan FEHB members have access to urgent care clinics owned by Intermountain Healthcare, such as Intermountain Instacare and Intermountain Kidscare. To find urgent care facilities, call Member Services at 844-345-FEHB, or visit our website at www.selecthealth.org/fehb.

If you have an emergency or need urgent care outside of the service area, participating benefits apply to services you receive in a doctor's office, urgent care facility, or emergency room. In an effort to reduce your medical out-of-pocket expenses incurred while traveling, SelectHealth Plan has made an arrangement with the Multiplan and PHCS networks of healthcare providers and facilities. They have agreed to accept an Allowed Amount for covered services, which means you will not be responsible for excess charges when using these providers. Always present your ID Card when visiting providers or facilities. The logos on the card give you access to these networks. To find Multiplan or PHCS providers and facilities, call Multiplan at 800-678-7427 or visit www.multiplan.com.

Benefit Description	You Pay After the calendar year deductible...
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: If you are admitted inpatient during an emergency room (ER) visit, the ER copay will be waived. Instead, Inpatient Hospital benefits will apply. Note: Intermountain KidsCare Clinics are owned by Intermountain Healthcare, and provide after hours urgent care services for pediatric patients. The clinic does not accept primary care patients.	$30 Urgent care or Intermountain InstaCare visit $10 Intermountain KidsCare visit $200 per visit Emergency Room Copay

Emergency within our service area - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Emergency within our service area (cont.)	
Note: The Instacare clinic is an Intermountain Healthcare urgent care clinic for patients of all ages. Also see Section 5(a) for Telehealth urgent care services.	$30 Urgent care or Intermountain InstaCare visit $10 Intermountain KidsCare visit $200 per visit Emergency Room Copay
Not covered: • *Elective care or non-emergency care*	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: If you are admitted inpatient during an emergency room (ER) visit, the ER copay will be waived. Instead, Inpatient Hospital benefits will apply. Note: Intermountain KidsCare Clinics are owned by Intermountain Healthcare, and provide after hours urgent care services for pediatric patients. The clinic does not accept primary care patients. Note: The Instacare clinic is an Intermountain Healthcare urgent care clinic for patients of all ages. Also see Section 5(a) for Telehealth urgent care services.	$30 Urgent care or Intermountain InstaCare visit $10 Intermountain KidsCare visit $200 per visit Emergency Room Copay
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside of the service area*	*All charges*
Ambulance	
Professional ambulance service (including air ambulance) when medically appropriate. Note: See Section 5(c) for non-emergency service.	$100 copay

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $1,500 for Self Only enrollment, $3,000 per Self Plus One enrollment and $3,000 per Self and Family enrollment each calendar year. The Self and Family and Self Plus One deductibles can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR INPATIENT AND RESIDENTIAL TREATMENT CENTER SERVICES.** Please refer to Section 3 for prior authorization information and to be sure with services require prior authorization.

Benefits Description	You Pay After the calendar year deductible...
Professional services	
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual, single-family, multi-family, or group therapy visits) • Diagnosis and treatment of alcoholism and drug use, including detoxification, treatment and counseling	$10 per office visit Nothing for inpatient or outpatient professional services $150 per day for outpatient facility services $150 per day up to $750 per admission for inpatient facility services

Professional services - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Professional services (cont.)	
• Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • ABA therapy Note: Inpatient and residential treatment admissions require preauthorization from your physician. See page 19. Note: For benefit information on the diagnostic and treatment services as well as ABA-related therapy, see Section 5(a) *Medical Services and Supplies Provided by Physicians and other Health Care Professionals*.	$10 per office visit Nothing for inpatient or outpatient professional services $150 per day for outpatient facility services $150 per day up to $750 per admission for inpatient facility services
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility Note: Inpatient and residential treatment admissions require preauthorization from your physician. See page 19.	$10 per office visit Nothing for minor diagnostic tests $150 copay for major diagnostic tests
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services Note: Inpatient and residential treatment admissions require preauthorization from your physician. See page 19.	$150 copay per day up to $750 per admission
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$10 per office visit $150 copay per day for outpatient facility services
Methadone maintenance, associated clinics or services	$10 per office visit to a primary care physician $30 per office visit to a specialist

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the following chart.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Federal law prevents the pharmacy from accepting unused medications.
- The deductible is $1,500 for Self Only enrollment, $3,000 per Self Plus One enrollment and $3,000 Self and Family enrollment each calendar year. The Self and Family and Self Plus One deductibles can be satisfied by one or more family members.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME PRESCRIPTION DRUGS.** Please contact Pharmacy Services to identify which prescription drugs require preauthorization.

There are important features you should be aware of. These include:

- **Who can write your prescription?** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, or by mail through Intermountain Home Delivery for a maintenance medication. Specialty drug prescriptions must be filled at Intermountain Specialty Pharmacy or a SelectHealth Plan Preferred Specialty Pharmacy. To find a participating pharmacy, call the SelectHealth Plan Pharmacy Department at 844-345-FEHB. To see the drugs covered by your plan, log in to your SelectHealth Plan Portal, or visit our website at www.selecthealth.org/fehb.
- **We have an closed formulary.** A closed formulary means all new drugs are reviewed prior to being added to the formulary (a list of covered drugs). A non-formulary drug prescribed by a Plan doctor requires a prior authorization to be covered by the plan. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from the formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug list, call 844-345-FEHB.
- Tier 1 is generic drugs. Tier 2 is preferred brand name drugs. Tier 3 is non-preferred brand name drugs. Tier 4 is for injectable drugs and specialty medications.
- **These are the dispensing limitations.** Except for schedule II controlled substances, refills are allowed after 75 percent of the last refill has been used for a 30-day supply (or greater than 30-day supply), and 50 percent for a 10-day supply. Some exceptions may apply, and the timing of refill limits may be adjusted as market dynamics change. Call Pharmacy Services at 844-345-FEHB for more information. You can also contact your pharmacy to find out if you are able to get a prescription refilled.
- **A generic equivalent will be dispensed if it is available**. If you receive a name brand drug when a Federally-approved generic drug is available, you have to pay the difference in cost between the name brand drug and the generic and the difference is not applied to your catastrophic protection out-of-pocket maximum.
- **Why use generic drugs?** A generic drug is a medication in which the active ingredients, safety, dosage, quality, and strength are identical to that of its brand-name counterpart. Generic drugs are regulated by the U.S. Food and Drug Administration just like brand-name drugs.

Benefit Description	You Pay After the calendar year deductible...
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Growth hormone therapy (GHT) • Insulin • Diabetic supplies: - Disposable needles and syringes for the administration of covered medications - Continuous glucose monitors • Drugs for sexual dysfunction Note: Selected prescription drugs and supplies require preauthorization from your physician as referenced on page 19. Contact SelectHealth Plan for information on a specific drug(s) as requirements may change due to new drugs, therapies, or other factors. Note: Drugs for sexual dysfunction are limited; contact SelectHealth Plan for more details on covered sexual dysfunction drugs. Note: GHT is only covered when a prior authorization has been approved for the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services under *You need prior Plan approval for certain services* on page 19. Note: Preauthorization and deductibles do not apply to Naloxone-based rescue agents. A tier 1 copay applies for a 30-day or 90-day timeframe.	Prescription Medications Tier 1 $7 Tier 2 $25 Tier 3 $50 Tier 4 30% of the allowed amount Mail Order Maintenance Medications - 90 day supply Tier 1 $7 Tier 2 $50 Tier 3 $150 Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Women's contraceptive drugs and devices: • Generic oral contraceptives on our formulary list • Generic emergency contraception, including OTC when filled with a prescription • Generic injectable contraceptives on our formulary list - five (5) vials per calendar year • Diaphragms - one (1) per calendar year • Generic patch contraception	Nothing

Benefit Description	You Pay After the calendar year deductible...
Preventive medications	
The following are covered: • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 and 800 mcg • Liquid iron supplements for children age 6 months - 1 year • Vitamin D supplements (prescription strength) (400 and 1000 units) for members 65 or older • Prenatal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 • Statin for adults aged 40-75 years with no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater Note: Preventive Medications with a USPSTF recommendations of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for urgent and/or emergencies out-of-area* • *Fertility drugs* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them except as required by the Affordable Care Act* • *Nonprescription medications medicines* • *Prescriptions dispensed in a provider's office are not covered unless expressly approved by SelectHealth Plan* *Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco and nicotine dependence are covered under the Tobacco Cessation benefit.* See page 88.	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating Benefits with Other Coverage*.
- Plan dentists must arrange your covered care.
- The deductible is $1,500 for Self Only enrollment, $3,000 per Self Plus One enrollment and $3,000 Self and Family enrollment each calendar year. The Self and Family and Self Plus One deductibles can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefits Description	You Pay After the calendar year deductible...
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair and/or replace sound natural teeth. The need for these services must result from an accidental injury.	$10 per office visit to a primary care physician $30 per office visit to a specialist $30 Urgent care or Intermountain Instacare visit $10 Intermountain KidsCare visit $200 emergency room
Dental benefits	
We have no other dental benefits	All charges

Section 5(h). Wellness and Other Special Features

Special feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claims process (see Section 8).
Member Services extended hours	Representatives are available during extended hours to answer questions and help resolve concerns. To contact Member Services, call 844-345-FEHB weekdays, from 7 a.m. to 8 p. m., and Saturdays, from 9 a.m. to 2 p.m.
SelectHealth Plan Member Advocates®	Whether you need help with behavioral or physical health, Member Advocates can help you find the right care for your needs. They can assist with the following: • Scheduling an appointment, including care for urgent conditions • Finding the closest facility or doctor with the nearest available appointment • Providing information about a doctor such as age, training certifications, and languages spoken • Helping you understand and maximize your benefits To contact Member Advocates, call 800-515-2220 weekdays, from 7 a.m. to 8 p.m., and Saturdays, from 9 a.m. to 2 p.m. To access the online provider directory, visit www.selecthealth.org/fehb.
Out-of-Area child(ren) dependent coverage	Dependent children residing outside the service area can receive participating benefits for covered services when using our MultiPlan and/or Private Healthcare System providers outside of Utah. A Dependent Address Change Form, for any dependent children residing outside the service area, must be filled out and submitted in order to receive this extended coverage. To access this form, please visit www.selecthealth.org/fehb. Otherwise, service access outside the service area is limited to only those services that meet the definition of urgent or emergency care. Federal employees, annuitants, and spousal dependents are not eligible for this extended out-of-area coverage. For the definition of eligible dependent children, please refer to FEHB Facts on page 9.

Special feature	Description
Services for deaf and hearing impaired	Free interpreting services will be provided upon request.
Tobacco Cessation Program	One of the most significant things a person can do to improve overall health is to quit smoking. We offer a free program that can help. Quit for Life® allows participants to progress at their own pace from home. For more information, call 866-784-8454.
Online tools	Our comprehensive package of online tools and resources allows you to search for participating doctors and facilities, find lower-cost medications, and even create a personalized fitness plan. The SelectHealth Plan Portal, our secure member website, allows you to manage your health information in one location. You can access the SelectHealth Plan Portal by logging in at www.selecthealth.org/fehb. Once you have logged in, you can access the following tools: • View your claims by accessing online Explanation of Benefits (EOBs) • Send a secure message to Member Services • View your pharmacy claims, and find participating pharmacies • Improve your health by taking a personal health assessment, tracking your progress, and utilizing other wellness tools • Access medical records, including lab, pathology, and imaging results, from Intermountain providers that use this program. E-mail questions to certain Intermountain providers
Member discounts	Embracing a healthy lifestyle is more convenient when it costs less. As a SelectHealth Plan member, you can access discounts on health-related products such as gym memberships, eyewear, LASIK, spas, and nutrition supplements. You can receive these discounts by simply showing your SelectHealth Plan ID Card. A complete list is available at www.selecthealth.org/discounts.
Working with Intermountain Healthcare	SelectHealth® Plan is a not-for-profit health plan serving more than 800,000 members in Utah and Idaho. For more than 35 years, we've been committed to helping our members and everyone in our communities stay healthy. In fact, we share a mission with Intermountain Healthcare®: *Helping people live the healthiest lives possible.*® Our integration with Intermountain Healthcare helps us ensure high-quality healthcare at the lowest possible cost for our members and the community.
SelectHealth Plan Healthy Beginnings®	Our prenatal program provides support and resources for expectant mothers. Registered nurses work with moms-to-be and their providers through every trimester and question. There's no catch and no cost. In addition to expert care and support, each enrollee receives a kit of education materials. The program encourages the following: 1. A prenatal exam prior to the 14th week of pregnancy. 2. A postpartum exam within 50 days of your delivery date. For more information, call Healthy Beginnings at 866-442-5052.
Preventive care	The goal of preventive care, such as regular checkups and screenings, is to help you avoid illness and to detect problems when they are most treatable. Your plan covers preventive care 100 percent—that means no deductible, copay or coinsurance. Examples of preventive services include the following: • Certain examinations and/or screenings (for example, a mammogram, colon and prostate cancer screenings, etc.) • Flu and pneumonia vaccinations

	• Certain screenings laboratory and X-ray tests (such as Pap smears or cholesterol tests) • Routine immunizations Checkups may include tests performed by your doctor to manage a known condition, such as treating high blood pressure to prevent a heart attack or a stroke. Services performed to maintain a known condition are not usually considered preventive. Your regular deductible, copay and/or coinsurance will apply to these services. SelectHealth Plan has always been committed to covering preventive services. However, not every preventive service is appropriate every year, and recommended screening guidelines may vary. We offer online resources that give you access to immunization schedules, tips for women's health, and information about preventive care exams and tests. You may also complete a personal health assessment and take quizzes about exercise and nutrition.
Care Management	Trained registered nurse care managers are available to assist you with various health concerns and can help coordinate services between providers and patients. Our Care Management Programs offer educational materials, newsletters, follow-up phone calls, and additional support. Care management covers these areas: • Allergies and rhinitis • Asthma • Cancer • Chronic obstructive pulmonary disease (COPD) • Depression • Diabetes • Heart disease • High-risk pregnancy • Migraines For more information, call Care Management at 800-442-5305.
Healthy Living℠	Participate in the Healthy Living program to improve your health. Complete a biometric screening and an online health assessment (through the SelectHealth Plan Portal) and receive an individualized health report. This can help you identify and address health risks. This information will not be shared with your employer. You can access the SelectHealth Plan Portal by logging in at www.selecthealth.org/fehb.
Intermountain Connect Care℠	Healthcare on your schedule - no lines, no waiting room. Intermountain Connect Care is a convenient way to talk to a provider about urgent medical issues, no appointment necessary. So don't suffer on vacation or wait when other options aren't available: Use your smartphone, tablet, or computer to connect to a provider within minutes. Download the app or visit www.intermountainconnectcare.org to get started. The providers at Connect Care can help you with: • Cough • Ear pain • Eye infection • Joint pain/strain • Lower back pain

	• Minor burns/rashes/skin infections • Sinus pain/pressure • Seasonal allergies • Sore throat • Urinary pain To save time, create a Connect Care account now so it will be ready when you need it. Your information will be stored securely for future visits.
Intermountain Health Answers	A phone call could save you money - and an ER visit. Instead of relying on the Internet for self-diagnosis, our members can pick up the phone and talk to a registered nurse at any time. This 24/7 services is available through Intermountain Health Answers, which is staffed by registered nurses and offered exclusively to our members and the uninsured. Using nationally standardized protocols, these nurses offer home-based remedies and make recommendations for when to seek care from a provider, urgent care clinic, or emergency room. Intermountain Health Answers is free and can help you make sense of your symptoms and determine how and where to get the best care. To reach Health Answers, you can call 844-501-6600.
Travel benefit/services overseas	If you are traveling outside of the country and need urgent or emergency care, visit the nearest doctor or hospital. Notify us of your circumstances as soon as possible. You may be required to pay for treatment at the time of service and then submit an itemized statement or claim to SelectHealth Plan. All services obtained outside of the United States unless routine, urgent or emergency condition require preauthorization. See page 19. Our Care Management team may become involved to help with any out-of-country health issues or claims that are particularly complicated. If you are outside of the SelectHealth Plan service area (more than 40 miles away from a participating provider or facility), participating benefits apply to services for urgent or emergency conditions rendered in any doctor’s office or any urgent care facility.
Intermountain Weight Management Program	Finding a balance of fitness and nutrition that works for your body is important for a lasting weight management program. The Intermountain Weight Management program is for overweight adults and children who want to lose weight, improve their health, and feel better every day. This program works because: • **It's personal**. You choose the classes that will help you learn the skills and knowledge you need. • **It's professional**. The program is led by registered dietitians with training and experience in weight management. Guest lectures are taught by professionals with other areas of expertise. • **It's proven**. The program is based on the latest evidence about what works for weight loss and for making changes that last a lifetime. SelectHealth Plan will cover the cost of the program once per calendar year for eligible members who complete all course requirements. Contact SelectHealth Plan at 844-345-FEHB to verify your coverage.
SelectHealth Plan Mobile App	If you've got your phone, we've got you covered. With the SelectHealth® Plan mobile app, you have access to your health plan whenever - and wherever - you need it. Access your insurance plan on the go. With our secure app, you can: • View, email, and fax images of your ID card • Search for doctors and hospitals • View your benefits and claims, including year-to-date totals

	• Look up pharmacies and medications Find us on Google Play® and the Apple® App Store.SM
Wellness incentive	Participate in the FEHB wellness incentive program to improve your health and earn an incentive. Eligible members must be age 18 or older and enrolled on a SelectHealth Plan FEHB plan option. Log in to the SelectHealth Plan Portal atwww.selecthealth.org/fehb to access the health risk assessment. Receive up to a combined total of either $75/per person or $200/family for completion of qualified wellness events. Contact Member Services at 844-345-FEHB or visit www.selecthealth.org/fehb for more information.

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 800-538-5038 or visit their website www.selecthealth.org.

Employee Assistance Program Services

Brief Counseling: Free, brief counseling for life problems such as conflict at work or with a family member, depression, anxiety, and life stress. Services are available to all SelectHealth Plan FEHB enrollees.

Elder Care Support: Information, resources, and coaching for employees who are providing assistance to a spouse or relative who is ill, disabled, or needs health with basic activities of daily living. Caregiver services can help identify medical, legal, and financial resources, as well as provide support for the emotional issues of caregiving.

Crisis Response Services: 24/7 phone crisis services with a licensed mental health professional.

Website: Visit www.intermountainhealthcare.org/eap for valuable resources for enrollees including Quick Tips on common life problems, resources such as "Our Favorite Books," and a sign up for bi-monthly LiVe Well E-Tips. You will also find details about our office locations and staff biographies.

Contact Us: Call 801-442-3509 or 800-832-7733 from 8:00 a.m. - 5:00 p.m. (MST) to schedule an appointment. A crisis counselor is available by phone 24/7 at the same number. You can also email us at eap@imail.org with non-urgent questions or feedback.

ChooseHealthy Program

American Specialty Health provides the following discounts for SelectHealth Plan FEHB members through their ChooseHealthy program:

- Acupuncture
- Therapeutic massage
- Physical & occupational therapy
- Podiatry

Members can select a provider on the ChooseHealthy website www.choosehealthy.com and get 25% off the UCR* for their visit.

*The usual, customary and reasonable (UCR) pricing refers to the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

Medicare Advantage

SelectHealth Plan offers a Medicare Advantage plan for individuals who are eligible for Medicare. SelectHealth Plan Advantage (HMO) is available in 16 counties across Utah. Call 855-442-9940 for information, or visit www.selecthealth.org/medicare.

Individual Plans

SelectHealth Plan offers many individual Plan options in Utah that are tailored to meet your needs. Call 800-538-5038 for more information, or visit www.selecthealth.org.

Section 6. General Exclusions - Services, Drugs and Supplies We Do Not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition**. **For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or urgent and/or emergency services (see *Emergency services/ accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies we are prohibited from covering under the Federal law.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your deductible, copayment or coinsurance.

You will only need to file a claim when you receive urgent and/or emergency services from non-Plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits	In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 844-345-FEHB weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m, or at our website at www.selecthealth.org/fehb. When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show: • Covered member's name, date of birth, address, phone number and ID number • Name and address of the provider or facility that provided the service or supply • Dates you received the services or supplies • Diagnosis • Type of each service or supply • The charge for each service or supply • A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN) • Receipts, if you paid for your services Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills. **Submit your claims to:** P.O. Box 30192 Salt Lake City, UT 84130-0192
Prescription drugs	**Submit your claims to:** P.O. Box 30192 Salt Lake City, UT 84130-0192
Other supplies or services	**Submit your claims to:** P.O. Box 30192 Salt Lake City, UT 84130-0192
Deadline for filing your claim	Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7, and 8 of this brochure, please call your Plan's customer service representative at the phone number found on your enrollment card, Plan brochure, or Plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Appeals Department by writing to P.O. Box 30192 Salt Lake City, UT 84130-0192 or calling toll-free at 844-208-9012.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: SelectHealth Plan, Appeals Department P.O. Box 30192 Salt Lake City, UT 84130-0192; by fax: 801-442-0762; or email us at appeals@imail.org; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or

b) Write to you and maintain our denial, or

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us toll-free at 844-208-9012. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.selecthealth.org/fehb.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgement, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your inquiry or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgement, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan by phone 877-888-3337 (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs - this plan does not cover these costs.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 800-MEDICARE (800-633-4227), (TTY 877-486-2048) or at www.medicare.gov.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan - You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 844-345-FEHB weekdays, from 7 a.m. to 8 p.m., and Saturdays, from 9 a.m. to 2 p.m. or see our website at www.selecthealth.org/fehb.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following table, it illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description	You pay without Medicare	You pay with Medicare Part B
Deductible	**Standard Option:** $250 Self Only $500 Self Plus One $500 Self and Family **HDHP Option** $1,500 Self Only $3,000 Self Plus One $3,000 Self and Family	**Standard Option:** $250 Self Only $500 Self Plus One $500 Self and Family **HDHP Option** $1,500 Self Only $3,000 Self Plus One $3,000 Self and Family
Out-of-Pocket Maximum	**Standard Option:** $5,500 Self Only $11,000 Self Plus One $11,000 Self and Family **HDHP Option:** $5,000 Self Only $10,000 Self Plus One $10,000 Self and Family	**Standard Option:** $5,500 Self Only $11,000 Self Plus One $11,000 Self and Family **HDHP Option:** $5,000 Self Only $10,000 Self Plus One $10,000 Self and Family
Part B Premium Reimbursement Offered	**Standard Option:** N/A **HDHP Option:** N/A	**Standard Option:** N/A **HDHP Option:** N/A
Primary Care Physician	**Standard Option**: $15 **HDHP Option**: $10	**Standard Option:** $15 **HDHP Option:** $10
Specialist	**Standard Option**: $35 **HDHP Option**: $30	**Standard Option:** $35 **HDHP Option:** $30
Inpatient Hospital	**Standard Option**: 15%* **HDHP Option**: $150 per day up to $750 per admission*	**Standard Option:** 15%* **HDHP Option:** $150 per day up to $750 per admission*
Incentives Offered	**Standard Option:** $75 per month Self Only $200 per month Self Plus One $200 per month Self and Family **HDHP Option:** $75 per month Self Only $200 per month Self Plus One $200 per month Self and Family	**Standard Option:** $75 per month Self Only $200 per month Self Plus One $200 per month Self and Family **HDHP Option:** $75 per month Self Only $200 per month Self Plus One $200 per month Self and Family
Outpatient Hospital	**Standard Option**: 15%* **HDHP Option**: $150 per day	**Standard Option:** 15%* **HDHP Option:** $150 per day

*after deductible

You can find more information about how our plan coordinates benefits with Medicare by calling Member Services at 844-345-FEHB weekdays, from 7 a.m. to 8 p.m., and Saturdays from 9 a.m. to 2 p.m.

- **Tell us about your Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about the other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

  To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY: 877-486-2048) or at www.medicare.gov.

  If you enroll in a Medicare Advantage plan, the following options are available to you:

  This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. If you are an annuitant or former spouse with FEHB coverage and are enrolled in our Medicare Parts A and B, you may enroll in our Medicare Advantage plan if one is available in your area. We do not waive cost-sharing for your FEHB coverage. For more information, please call us at 855-442-9940.

  This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

  However, we will not waive any of our copayments or coinsurance. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

  Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

  When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Autism Spectrum Disorder	Autism Spectrum Disorder includes disorders characterized by delays in the development of multiple basic functions, including socialization and communication. Autism Spectrum Disorder includes: Asperger's Syndrome; Autistic Disorder; Childhood Disintegrative Disorder; and Pervasive development disorder not otherwise specified.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical trials cost categories	An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application. • Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy • Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care • Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	See Section 4, page 24.
Copayment	See Section 4, page 24.
Cost-sharing	See Section 4, page 24.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Services provided primarily to maintain rather than improve a member's condition or for the purpose of controlling or changing the member's environment. Services requested for the convenience of the member or the member's family that do not require the training and technical skills of a licensed nurse or other licensed provider, such as convalescent care, rest cures, nursing home services, etc. Services that are provided principally for personal hygiene or for assistance in daily activities.
Deductible	See Section 4, page 24.
Experimental and/or investigational	A service for which one or more of the following apply: • It cannot be lawfully marketed without the approval of the FDA and such approval has not been granted at the time of its use or proposed use; • It is the subject of a current investigational new drug or new device application on file with the FDA; • It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial; • It is being or should be delivered or provided subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS); or

- If the predominant opinion among appropriate experts as expressed in the peer-reviewed medical literature is that further research is necessary in order to define safety, toxicity, effectiveness, or comparative effectiveness, or there is no clear medical consensus about the role and value of the service.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Major surgery

A surgical procedure having one or more of the following characteristics:

- Performed within or upon the contents of the abdominal, pelvic, cranial or thoracic cavities,
- Typically requiring general anesthesia,
- Has a level of difficulty or length of time to perform which constitutes a hazard to life or function of an organ or tissue, or
- Requires the special training to perform.

Medical necessity

Services that a prudent healthcare professional would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

- in accordance with generally accepted standards of medical practice in the United States;
- clinically appropriate in terms of type, frequency, extent, site, and duration; and
- not primarily for the convenience of the patient, physician, or other provider. When a medical question-of-fact exists, medical necessity shall include the most appropriate available supply or level of service for the member in question, considering potential benefit and harm to the member.

Medical necessity is determined by the treating physician and by the SelectHealth Plan Medical Director or his or her designee. The fact that a provider or facility, even a participating provider or facility, may prescribe, order, recommend, or approve a service does not make it medically necessary, even if it is not listed as an exclusion or limitation. FDA approval, or other regulatory approval, does not establish medical necessity.

Observation care

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. A clinical decision for admission or discharge is typically made within 48 hours.

Participating provider

Providers under contract with SelectHealth Plan to accept allowed amounts as payment in full for covered services. If you have questions about your benefits, call Member Services at 844-345-FEHB, or visit www.selecthealth.org/fehb. Member Services can also provide you with a provider directory and information about participating providers, such as medical school attended, residency completed and board certification status. SelectHealth Plan offers foreign language assistance.

Plan allowance/allowed amount

Plan allowance is the amount we use to determine our payment and your responsibility for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: SelectHealth Plan determines how much is allowed for covered services through the use of a maximum allowable fee or the out-of-area fee schedule.

Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Premium pass through	The Plan passes through a portion of the health plan premium as a deposit to the HSA each month OR amount credited to your HRA account.
Pre-service claims	Those claims (1) that require preauthorization, prior approval, or a referral and (2) where failure to obtain preauthorization, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve pre-service claims and not post-service claims. We will evaluate whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Member Services at 844-345-FEHB. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Us/We	Us and We refer to SelectHealth Plan.
You	You refers to the enrollee and each covered family member.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of Benefits for the Standard Option SelectHealth Plan - 2021

- **Do not rely on this chart alone**. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.selecthealth.org/fehb.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by participating providers and facilities, except in urgent and/or emergency situations.
- Below, an asterisk (*) means the item is subject to the $250 single, $500 family calendar year deductible.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services in the office	Office visit copay: $15 primary care; $35 specialist	29
Services provided by a hospital:		
• Inpatient	15% of the allowed amount*	48
• Outpatient	15% of the allowed amount*	49
Emergency benefits:		
• In-area	$200 copay*	51
• Out-of-area	$200 copay*	52
Mental health and substance use disorder treatment:	Same as medical; specialist office copay does not apply	53
Prescription drugs:		
• Retail pharmacy	Tier 1 $5 Tier 2 $40 after deductible Tier 3 50% of the allowed amount up to $250* Tier 4 30% of the allowed amount*	56
• Mail order	Tier 1 $5 Tier 2 $80 after deductible Tier 3 50% of the allowed amount*	56
Dental care:	No benefit	58
Vision Care:	$0 copay Preventive exam $15 copay PCP office visit $35 copay Specialist office visit Eyewear is not covered	37
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $5,500 per person ($11,000 per Self Plus One enrollment, and $11,000 per Self and Family enrollment). Some costs do not count toward this protection	25

Summary of Benefits for the HDHP Option SelectHealth Plan - 2021

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.SelectHealth.org/fehb. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

In 2021, for each month you are eligible for the Health Savings Account (HSA), SelectHealth Plan will deposit $75.00 per month for Self Only enrollment, $150.00 for Self Plus One enrollment or $150.00 per month for Self and Family enrollment to your HSA. For the HSA, you may use your HSA dollars or pay out of pocket to satisfy your calendar year deductible of $1,500 for Self Only, $3,000 for Self Plus One and $3,000 for Self and Family. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA fund of $900 for Self Only, $1,800 for Self Plus One, and $1,800 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Below, an asterisk (*) means the item is subject to the calendar year deductible. Plan physicians must provide or arrange your care.

HDHP Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $30 specialist*	78
Services provided by a hospital:		
• Inpatient	$150 per day up to $750 per admission*	96
• Outpatient	$150 copay per day*	97
Emergency benefits		
• In-area	$200 copay*	99
• Out-of-area	$200 copay*	100
Mental Health and substance use disorder treatment:	Same as medical; specialist office copay does not apply	101
Prescription drugs:		
• Retail pharmacy	Tier 1 $7* Tier 2 $25* Tier 3 $50* Tier 4 30% of the allowed amount*	104
• Mail order	Tier 1 $7* Tier 2 $50* Tier 3 $150*	104
Dental care:	No benefit	106
Vision care:	$0 Copay Preventive exam $10 Copay PCP office visit* $30 Copay Specialist office visit* Eyewear is not covered	85

HDHP Option Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $5,000 per person ($10,000 per Self Plus One enrollment, and $10,000 per Self and Family enrollment). Some costs do not count toward this protection	25

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2021 Rate Information for SelectHealth Plan

To compare your FEHB health plan options, please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to certain United States Postal Service employees as follows:

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreement: NALC.
- **Postal Category 2** rates apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees and career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NPMHU, NPPN and NRLCA. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.

If you are a Postal Service employee and have questions or require assistance, please contact:

USPS Human Resources Shared Service Center: 1-877-477-3273, option 5, Federal Relay Service 1-800-877-8339

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Utah							
Standard Option Self Only	SF4	$217.60	$72.53	$471.47	$157.15	$69.63	$60.20
Standard Option Self Plus One	SF6	$478.72	$159.57	$1,037.22	$345.74	$153.19	$132.45
Standard Option Self and Family	SF5	$544.00	$181.33	$1,178.66	$392.89	$174.08	$150.51
Utah							
HDHP Option Self Only	WX1	$186.74	$62.25	$404.61	$134.87	$59.76	$51.67
HDHP Option Self Plus One	WX3	$410.83	$136.94	$890.13	$296.71	$131.46	$113.66
HDHP Option Self and Family	WX2	$466.85	$155.62	$1,011.52	$337.17	$149.39	$129.16