The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. **This is only a summary.** Please read the FEHB Plan brochure [RI 71-005] that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can get the FEHB Plan brochure at fepblue.org/brochure, and view the Glossary at www.dol.gov/ebsa/healthreform. You can call 1-800-411-BLUE to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 350/Self Only $ 700/Self Plus One $ 700/Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Preferred providers $5,000 Self Only / $10,000 Self Plus One or Self and Family; for Non-preferred providers $7,000 Self Only / $14,000 Self Plus One or Self and Family	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover. Please review exceptions in Section 4 in brochure RI 71-005.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Will you pay less if you use a network provider?	Yes. See fepblue.org/provider or call your local BCBS company for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit. Deductible does not apply.	35% coinsurance	None
	Specialist visit	$35/visit. Deductible does not apply.	35% coinsurance	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	35% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	35% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	35% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most, plus you may be balance billed)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at fepblue.org/pharmacy	Tier 1 (Generic drugs)	Retail: $7.50/prescription Mail service: $15/prescription. Deductible does not apply.	45% of the average wholesale price (AWP) Deductible does not apply.	Covers 30-day supply, up to 90-day supply for additional copayments. Prior approval is required for certain prescription drugs. You must pay the full cost of a drug purchased at a Non-Preferred pharmacy and file a claim for reimbursement.
	Tier 2 (Preferred brand drugs)	Retail: 30% coinsurance Mail service: $90/prescription. Deductible does not apply.	45% of the average wholesale price (AWP) Deductible does not apply.	
	Tier 3 (Non-preferred brand drugs)	Retail: 50% coinsurance Mail service: $125/prescription. Deductible does not apply.	45% of the average wholesale price (AWP) Deductible does not apply.	
	Tier 4 (Preferred specialty drugs)	Retail: 30% coinsurance Specialty pharmacy: $50/prescription (30-day supply); $140/prescription (90-day supply). Deductible does not apply.	45% of the average wholesale price (AWP) Deductible does not apply.	Covers up to a 30-day supply, one fill limit (Retail) 90-day supply can only be obtained after 3rd fill (Specialty pharmacy) Prior approval is required for certain prescription drugs. You must pay the full cost of a drug purchased at a Non-Preferred pharmacy and file a claim for reimbursement.
	Tier 5 (Non-preferred specialty drugs)	Retail: 30% coinsurance Specialty pharmacy: $70/prescription (30-day supply); $200/prescription (90-day supply). Deductible does not apply.	45% of the average wholesale price (AWP) Deductible does not apply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	35% coinsurance for member and non-member facilities	Prior approval is required for certain surgical services
	Physician/surgeon fees	15% coinsurance	35% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most, plus you may be balance billed)	
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	You pay nothing when you receive care for your accidental injury within 72 hours.
	Emergency medical transportation	$100/day. Deductible does not apply.	$100/day. Deductible does not apply.	Air or sea ambulance: $150/day You pay nothing when you receive care for your accidental injury within 72 hours.
	Urgent care	$30/visit. Deductible does not apply.	35% coinsurance	You pay nothing when you receive care for your accidental injury within 72 hours.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350/admission. Deductible does not apply.	$450/admission and 35% coinsurance. Deductible does not apply.	Precertification is required. We will reduce benefits for the inpatient hospital stay by $500 if no one contacts us for precertification.
	Physician/surgeon fees	15% coinsurance	35% coinsurance	Prior approval is required for certain surgical services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25/visit for professional services. Deductible does not apply. 15% coinsurance for other outpatient services	35% coinsurance	None
	Inpatient services	No charge for professional services; $350/admission for facility care. Deductible does not apply.	35% coinsurance for professional services; 35% coinsurance for facility care. Deductible does not apply.	Precertification is required for inpatient hospital stays. We will reduce benefits for the inpatient hospital stay by $500 if no one contacts us for precertification.
If you are pregnant	Office visits	No charge. Deductible does not apply.	35% coinsurance	None
	Childbirth/delivery professional services	No charge. Deductible does not apply.	35% coinsurance	None
	Childbirth/delivery facility services	No charge. Deductible does not apply.	35% coinsurance	None
If you need help recovering or have other special health needs	Home health care	15% coinsurance	35% coinsurance	50 visit limit/calendar year
	Rehabilitation services	Outpatient cardiac rehab: 15% coinsurance Physical, occupational, speech and cognitive	35% coinsurance	75 visit limit/calendar year. Includes physical, occupational and speech therapies

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most, plus you may be balance billed)	
		therapies: $25/visit for primary care provider, $35/visit (specialist). Deductible does not apply.		
	Habilitation services	$25/visit for primary care provider, $35/visit (specialist). Deductible does not apply.	35% coinsurance	75 visit limit/calendar year. Coverage is limited to physical, occupational and speech therapies
	Skilled nursing care	$175. Deductible does not apply.	$275 plus 35% coinsurance. Deductible does not apply.	30 day visit limit. See section 5(c). No coverage for members with Medicare Part A primary.
	Durable medical equipment	15% coinsurance	35% coinsurance	None
	Hospice services	No charge. Deductible does not apply.	Traditional Home (Member/Non-member facilities): $450 copayment/episode. Deductible does not apply. Continuous Home and Inpatient (Member facilities): $450/episode. Deductible does not apply. Continuous Home and Inpatient (Non-member facilities): $450/admission plus 35% coinsurance. Deductible does not apply.	Prior approval is required for all hospice services. Benefits are provided for up to 30 consecutive days in a facility licensed as an inpatient hospice facility.
If your child needs dental or eye care	Children's eye exam	$25/visit (primary care). Deductible does not apply. $35/visit (specialist). Deductible does not apply.	35% coinsurance	Coverage limited to exams related to treatment of a specific medical condition

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most, plus you may be balance billed)	
	Children's glasses	15% coinsurance	35% coinsurance	Coverage limited to one pair of glasses per incident prescribed for certain medical conditions
	Children's dental check-up	Up to age 13: The difference between $12 and the Maximum Allowable Charge (MAC). Deductible does not apply. Age 13 and over: The difference between $8 and the MAC. Deductible does not apply.	All charges above the fee schedule amount. Deductible does not apply.	Coverage limited to two per person per calendar year

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

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

- Acupuncture (24 visit limit/calendar year)
- Bariatric surgery
- Chiropractic care (12 visit limit/calendar year)
- Dental care (Adult)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine foot care if you are under active treatment for a metabolic or peripheral vascular disease

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

receive temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact your local BCBS Company at the customer service number on the back of your Standard Option ID card.

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

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

Language Access Services:
[Spanish (Español): Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identific ación.]
[Tagalog (Tagalog): Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.]
[Chinese (中文): 請撥打您 ID 卡上的客服號碼以尋求中文協助。]
[Navajo (Dine): Diné k'ehjí yá'áti' bee shíká'adoowoł nohsingo naaltsoos nihaa halne'go nidaahtinígíí bine'déé' Customer Service bibéésh bee hane'é biká'ígíí bich'į' dahodoołnih.]

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

The plan's overall deductible	$350
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	$350
Other *[cost sharing]*	15%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$90**

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

The plan's overall deductible	$350
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	$350
Other *[cost sharing]*	15%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$350
Copayments	$190
Coinsurance	$1400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,000**

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

The plan's overall deductible	$350
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	$350
Other *[cost sharing]*	15%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$210
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$560**

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