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. You can get the FEHB Plan brochure at www.fepblue.org/brochure or by calling 1-800-411-BLUE.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 350/Self Only $ 700/Self and Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for certain covered services you use. **Copayments** and **coinsurance** amounts do not count toward your **deductible**, which generally starts over January 1. When a covered service/supply is subject to a **deductible**, only the Plan allowance for the service/supply counts toward the **deductible**. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible** and which services are subject to the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Using Preferred providers: $5,000 (Self Only coverage); $6,000 (Self and Family coverage) Using Non-preferred providers: $7,000 (Self Only coverage; $8,000 (Self and Family coverage)	The **out-of-pocket limit,** or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for healthcare expenses.
What is not included in the out–of–pocket limit?	Please review Section 4 in brochure RI 71-005.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. A list of **Preferred providers** is available at fepblue.org/provider.	If you use an in-network doctor or other healthcare **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. [We use the terms **preferred** or participating for **providers** in our **network**.] See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See this plan's FEHB brochure for additional information about **excluded services**.

Questions: Call the phone number on the back of your ID card or visit us at www.fepblue.org/contact to find your local Plan's phone number.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.fepblue.org/sbc, or call 1-800-411-BLUE to request a copy.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider (plus you may be balance billed)	Limitations & Exceptions
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	35% coinsurance	None
	Specialist visit	$30/visit	35% coinsurance	None
	Other practitioner visit	Chiropractor: $20/visit Acupuncture: 15% coinsurance	35% coinsurance	Manipulative treatment: Covers a combined total of 12 visits per member per calendar year. Acupuncture: Covers up to 24 visits per calendar year.
	Preventive care/screening/ immunization	No charge	35% coinsurance	Limited to one per year for each covered service
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
If you need drugs to treat your illness or condition ***(continued next page)***	Tier 1: Generic drugs	Retail: 20% coinsurance Mail service: $15/prescription	45% coinsurance	Retail: Covers up to a 90-day supply Mail service: Covers 22-90 day supply Certain prescription drugs require prior approval.
	Tier 2: Preferred brand drugs	Retail: 30% coinsurance Mail service: $80/prescription	45% coinsurance	
	Tier 3: Non-preferred brand drugs	Retail: 45% coinsurance Mail service: $105/prescription	45% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider (plus you may be balance billed)	Limitations & Exceptions
More information about **prescription drug coverage** is available at fepblue.org/pharmacy.	Tier 4: Preferred specialty medications	Retail: 30% coinsurance Specialty pharmacy: $35/prescription (30-day supply); $95/prescription (90-day supply)	45% coinsurance	Retail: Tier 4 and 5 specialty drugs are limited to a 30-day supply; only one fill allowed Specialty pharmacy: 90-day supply can only be obtained after 3rd fill Certain prescription drugs require prior approval.
	Tier 5: Non-preferred specialty medications	Retail: 30% coinsurance Specialty pharmacy: $55/prescription (30-day supply); $155/prescription (90-day supply)	45% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	35% coinsurance for member and non-member facilities	You must get prior approval for certain surgical services.
	Physician/surgeon fees	15% coinsurance	35% coinsurance	
If you need immediate medical attention	Emergency room services	15% coinsurance	15% coinsurance	Limited to medical emergencies
	Emergency medical transportation	$100/day	$100/day	Air or sea ambulance: $150/day
	Urgent care	$30/visit	35% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/admission	$350/admission and 35% coinsurance	Precertification is required
	Physician/surgeon fee	15% coinsurance	35% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider (plus you may be balance billed)	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$20/visit for professional services and 15% coinsurance for other outpatient services	35% coinsurance	None
	Mental/behavioral health inpatient services	No charge for professional visits; $250/admission for facility care	35% coinsurance for professional visits; 35% coinsurance for facility care	Precertification of inpatient hospital stays is required
	Substance use disorder outpatient services	$20/visit for professional services and 15% coinsurance for other outpatient services	35% coinsurance	None
	Substance use disorder inpatient services	No charge for professional visits; $250/admission for facility care	35% coinsurance for professional visits; 35% coinsurance for facility care	Precertification of inpatient hospital stays is required
If you are pregnant	Prenatal and postnatal care	No charge	35% coinsurance	Home tocolytic therapy is not covered
	Delivery and all inpatient services	No charge	35% coinsurance	None
If you need help recovering or have other special health needs ***(continued next page)***	Home health care	15% coinsurance	35% coinsurance	Covers up to 50 visits per calendar year
	Rehabilitation services	Outpatient cardiac rehab: 15% coinsurance Physical, occupational, speech and cognitive therapies: $20/visit for primary care provider, $30/visit (specialist)	35% coinsurance	Benefits for physical, occupational, and speech therapies are limited to a combined total of 75 visits per member per calendar year as long as medically necessary and therapies are improving functionality
	Habilitation services	Physical, occupational, and speech therapies: $20/visit for primary care provider, $30/visit (specialist)	35% coinsurance	Benefits for physical, occupational, and speech therapies are limited to a combined total of 75 visits per member per calendar year as long as medically necessary and therapies are improving functionality

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider (plus you may be balance billed)	Limitations & Exceptions
If you need help recovering or have other special health needs, *continued*	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	15% coinsurance	35% coinsurance	None
	Hospice service	Traditional Home Hospice: No charge Continuous Home Hospice: $250/episode Inpatient Hospice: No charge	Traditional Home Hospice: No charge Continuous Home Hospice: $350/episode Inpatient Hospice: $350/admission plus 35% coinsurance	Prior approval from the Local Plan 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	Eye exam	$20/visit (PCP); $30/visit (specialist)	35% coinsurance	Coverage limited to exams related to treatment of a specific medical condition
	Glasses	15% coinsurance	35% coinsurance	Limited to one pair of glasses per incident prescribed for certain medical conditions
	Dental check-up	Up to age 13: The difference between $12 and the Maximum Allowable Charge (MAC) Age 13 and over: The difference between $8 and the MAC	All charges above the fee schedule amount	Limited to two per person per calendar year

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot care
- Skilled nursing care
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental care
- Hearing Aids
- Non-emergency care when traveling outside the U.S. See www.fepblue.org/overseas

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at the phone number on the back of your ID card, or visit www.opm.gov/insure/health.

Your Appeal Rights:

If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. For information about your **appeal** rights please see Section 3, "How you get care," and Section 8, "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact your local Plan at the phone number on the back of your ID card.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al numero de teléfono para Servicio al Cliente localizado atrás de su tarjeta de identificación.]

[Tagalog (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog pakitawagan ang numero ng telepono ng Serbisyo sa Kostumer na nakasulat sa likod ng inyong Identification Card.]

[Chinese (中文): 如果您需要華語援助, 請致電給會員證背面的客戶服務電話號碼.]

[Navajo (Dine): Diné k'ehjí yá'áti' bee shíká'adoowoł nohsingo naaltsoos nihaa halne'go nidaahtinígíí bine'dée' 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 page.

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,390
- **Patient pays** $150

Sample care costs:

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

Patient pays:

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

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,040
- **Patient pays** $1,360

Sample care costs:

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

Patient pays:

Deductibles	$350
Copays	$200
Coinsurance	$730
Limits or exclusions	$80
Total	**$1,360**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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