

 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 71-017] that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can get the FEHB Plan brochure at [www.fepblue.org/brochure](http://www.fepblue.org/brochure), and view the Glossary at [www.dol.gov/ebsa/healthreform](http://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:
<b>What is the overall deductible?</b>	\$ <a href="#">500</a> /Self Only \$ <a href="#">1,000</a> /Self Plus One \$ <a href="#">1,000</a> /Self and Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Preventive care, 10 office visits, telehealth, urgent care, manipulation treatments, and acupuncture are covered before you meet your deductible.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	\$ <a href="#">6,500</a> /Self Only \$ <a href="#">13,000</a> /Self Plus One \$ <a href="#">13,000</a> /Self and Family	The <a href="#">out-of-pocket limit</a> , or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover. Please review exceptions in Section 4 in brochure [RI 71-017].	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://fepblue.org/provider">fepblue.org/provider</a> or call your local BCBS company for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's charge</a> and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services



		(such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$10/visit. <u>Deductible</u> does not apply.	Not covered	10 visits/calendar year for primary care, specialists, and other healthcare professionals combined. Deductible and coinsurance applies starting on the 11 <sup>th</sup> visit.
	<u>Specialist</u> visit	\$10/visit. <u>Deductible</u> does not apply.	Not covered	10 visits/calendar year for primary care, specialists and other healthcare professionals combined. Deductible and coinsurance applies starting on the 11 <sup>th</sup> visit.
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	Not covered	Prior approval is required. There is a \$100 penalty if prior approval is not obtained.

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://fepblue.org/pharmacy">fepblue.org/pharmacy</a>	Tier 1 (Preferred generic drugs)	\$5/prescription. <u>Deductible</u> does not apply.	Not covered	Covers 30-day supply, up to 90-day supply for additional copayments. Non-preferred generic drugs are excluded.
	Tier 2 (Preferred brand-name drugs, Preferred generic <u>specialty drugs</u> and Preferred brand-name <u>specialty drugs</u> )	40% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Not covered	Up to \$350/prescription for a 30-day supply. Preferred brand-name drugs are covered up to a 90-day supply for up to \$1,050. Non-preferred brand name drugs and Non-preferred specialty drugs are excluded.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Not covered	Prior approval is required for certain surgical services. There is a \$100 penalty if prior approval is not obtained.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	Prior approval is required for certain surgical services. There is a \$100 penalty if prior approval is not obtained.
<b>If you need immediate medical attention</b>	Emergency room care	30% <u>coinsurance</u>	30% <u>coinsurance</u>	You pay nothing when you receive care for your accidental injury within 72 hours.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	You pay nothing when you receive care for your accidental injury within 72 hours.
	<u>Urgent care</u>	\$25/visit. <u>Deductible</u> does not apply.	Not covered	You pay nothing when you receive care for your accidental injury within 72 hours.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered	Precertification is required. We will reduce benefits for the inpatient hospital stay by \$500 if no one contacts us for precertification.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	Prior approval is required for certain surgical services. There is a \$100 penalty if prior approval is not obtained.

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 mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u>	Not covered	None
	Inpatient services	30% <u>coinsurance</u>	Not covered	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. <u>Deductible</u> does not apply.	Not covered	Prior notification is requested.
	Childbirth/delivery professional services	No charge. <u>Deductible</u> does not apply.	Not covered	Prior notification is requested.
	Childbirth/delivery facility services	\$1,500 copayment. <u>Deductible</u> does not apply.	Not covered	Prior notification is requested.
If you need help recovering or have other special health needs	<u>Home health care</u>	\$25/visit. <u>Deductible</u> does not apply.	Not covered	10 visits/calendar year
	<u>Rehabilitation services</u>	\$25/visit. <u>Deductible</u> does not apply.	Not covered	25 visits/calendar year. Includes physical, occupational and speech therapies.
	<u>Habilitation services</u>	\$25/visit. <u>Deductible</u> does not apply.	Not covered	25 visits/calendar year. Coverage is limited to physical, occupational and speech therapies.
	<u>Skilled nursing care</u>	Not covered	Not covered	None
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	Not covered	Some services require prior authorization. There is a \$100 penalty if prior approval is not obtained.
	<u>Hospice services</u>	Traditional Home: No charge Continuous Home and Inpatient: 30% <u>coinsurance</u>	Not covered	Prior approval is required for all hospice services. There is a \$100 penalty if prior approval is not obtained. 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	30% <u>coinsurance</u>	Not covered	Coverage is limited to exams related to treatment of a specific medical condition.
	Children's glasses	30% <u>coinsurance</u>	Not covered	Coverage is limited to one pair of glasses per

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 dental check-up	Not covered	Not covered	incident prescribed for certain medical conditions. None

### 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.)

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Weight loss programs</li> </ul> |
|---|---|--|

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

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Acupuncture (10 visits combined with chiropractic care/calendar year)</li> <li>• Bariatric surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care (10 visits combined with acupuncture/calendar year)</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care if you are under active treatment for a metabolic or peripheral vascular disease</li> </ul> |
|--|---|--|

**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](http://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](http://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 FEP Blue Focus 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 identificación.]

[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'adoowł nohsingo naaltsoos nihaa halne'go nidaahinígíí bine'déé' Customer Service bibéesh bee hane'é biká'ígíí bich'í' dahodoolnih.]

---

*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 \$500
- Specialist [cost sharing] \$10
- Hospital (facility) [cost sharing] \$1,500
- Other [cost sharing] 30%

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1560</b>

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

- The plan's overall deductible \$500
- Specialist [cost sharing] \$10
- Hospital (facility) [cost sharing] 30%
- Other [cost sharing] 30%

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$160
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2920</b>

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

- The plan's overall deductible \$500
- Specialist [cost sharing] \$10
- Hospital (facility) [cost sharing] 30%
- Other [cost sharing] 30%

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

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$380
Copayments	\$120
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$500</b>