### BlueCross® BlueShield® Service Benefit Plan: Basic Option

**Coverage Period:** 01/01/2015 – 12/31/2015

**Coverage for:** Self Only -or- Self and Family | Plan Type: PPO

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**Summary of Benefits and Coverage**

**Important Questions**

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the chart starting on page 2 for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>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.</td>
</tr>
<tr>
<td>Is there an out–of–pocket limit on my expenses?</td>
<td>Yes. $5,500 (Self Only coverage); $7,000 (Self and Family coverage)</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out–of–pocket limit?</td>
<td>Please review Section 4 in brochure RI 71-005.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. A list of Preferred providers is available at fepblue.org/provider.</td>
<td>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.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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**Questions:** Call the phone number on the back of your ID card or visit us at [www.fepblue.org/contact](http://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](http://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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Provider</th>
<th>Your Cost If You Use a Non-Preferred Provider (plus you may be balance billed)</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a healthcare provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25/visit</td>
<td>Not covered</td>
<td>You pay 30% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$35/visit</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other practitioner visit</td>
<td>Chiropractor: $25/visit Acupuncture: $25/visit (primary care provider), $35/visit (specialist)</td>
<td>Not covered</td>
<td>Manipulative treatment: Covers a combined total of 20 visits per member per calendar year Acupuncture: Covers up to 10 visits per calendar year, plus you pay 30% coinsurance for drugs and supplies</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>Limited to one per year for each covered service</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (X-ray, blood work)</td>
<td>No charge for blood work; $40 for X-rays</td>
<td>Not covered</td>
<td>You pay 30% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100 (when billed by professionals); $150 (billed by facilities)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition (continued)</td>
<td>Tier 1: Generic drugs</td>
<td>$10/prescription</td>
<td>Not covered</td>
<td>Covers 30-day supply, up to 90-day supply for additional copayments</td>
</tr>
<tr>
<td></td>
<td>Tier 2: Preferred brand drugs</td>
<td>$45/prescription</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3: Non-preferred brand drugs</td>
<td>50% coinsurance ($55 minimum)</td>
<td>Not covered</td>
<td></td>
</tr>
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<td>Common Medical Event</td>
<td>Services You May Need</td>
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| More information about prescription drug coverage is available at fepblue.org/pharmacy | Tier 4: Preferred specialty medications | Retail: $60/prescription (30-day supply)  
Specialty pharmacy: $50/prescription (30-day supply); $140/prescription (90-day supply) | Not covered | Retail: Tier 4 and 5 specialty drugs are limited to a 30-day supply; only one fill allowed |
| | Tier 5: Non-preferred specialty medications | Retail: $80/prescription (30-day supply)  
Specialty pharmacy: $70/prescription (30-day supply); $195/prescription (90-day supply) | Not covered | Specialty pharmacy: 90-day supply can only be obtained after 3rd fill  
Certain prescription drugs require prior approval. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | $100/day per facility | Not covered | Prior approval is required for certain surgical services.  
You pay 30% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care. |
<p>| | Physician/surgeon fees | $150/performing surgeon (office setting); $200/performing surgeon (other settings) | Not covered | |
| If you need immediate medical attention | Emergency room services | $125/visit | $125/visit | None |
| | Emergency medical transportation | $100/day | $100/day | Air or sea ambulance: $150/day |
| | Urgent care | $35/visit | Not covered | None |
| If you have a hospital stay (continued next page) | Facility fee (e.g., hospital room) | $175/day up to maximum of $875 per admission | Not covered | Precertification is required |</p>
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</thead>
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<tr>
<td>If you have a hospital stay</td>
<td>Physician/surgeon fee</td>
<td>$200/performing surgeon</td>
<td>Not covered</td>
<td>Precertification is required. You pay 30% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/behavioral health outpatient services</td>
<td>$25/visit</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Mental/behavioral health inpatient services</td>
<td>No charge for professional visits; $175/day up to maximum of $875 per admission for facility care</td>
<td>Not covered</td>
<td>Precertification of inpatient hospital stays is required</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$25/visit</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>No charge for professional visits; $175/day up to maximum of $875 per admission for facility care</td>
<td>Not covered</td>
<td>Precertification of inpatient hospital stays is required</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>Not covered</td>
<td>Home tocolytic therapy is not covered</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$175/admission for facility care</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs (continued next page)</td>
<td>Home health care</td>
<td>$25/visit</td>
<td>Not covered</td>
<td>Covers up to 25 visits per calendar year</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$25/visit; $35/visit for specialist</td>
<td>Not covered</td>
<td>Benefits for physical, occupational, and speech therapies are limited to a combined total of 50 visits per member per calendar year as long as medically necessary and therapies are improving functionality. You pay 30% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care.</td>
</tr>
</tbody>
</table>
### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>If you need help recovering or have other special health needs, continued</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Provider</th>
<th>Your Cost If You Use a Non-Preferred Provider (plus you may be balance billed)</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habilitation services</td>
<td>Physical, occupational, and speech therapies: $25/visit for primary care provider, $35/visit for specialist</td>
<td>Not covered</td>
<td>Benefits for physical, occupational, and speech therapies are limited to a combined total of 50 visits per member per calendar year as long as medically necessary and therapies are improving functionality. You pay 30% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care.</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>30% coinsurance</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Hospice service</td>
<td>Traditional Home Hospice: No charge Continuous Home Hospice: $150/day up to maximum of $750 per episode Inpatient Hospice: No charge</td>
<td>Not covered</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td>$25/visit—primary care provider; $35/visit—specialists</td>
<td>Not covered</td>
<td>Coverage limited to exams related to treatment of a specific medical condition</td>
<td></td>
</tr>
<tr>
<td>Glasses</td>
<td>30% coinsurance</td>
<td>Not covered</td>
<td>Limited to one pair of glasses per incident prescribed for certain medical conditions</td>
<td></td>
</tr>
<tr>
<td>Dental check-up</td>
<td>$25/evaluation</td>
<td>Not covered</td>
<td>Up to 2 per calendar year</td>
<td></td>
</tr>
</tbody>
</table>

### 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

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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.

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’ehji yá’áti’ bee shiká’adoowol nohsingó naaltsosó nihaa halne’go nidaahtííí bine’déé’ Customer Service bibéésh bee hane’é biká’ííí bichí? dahodoolníih.]

—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:** $7,200
- **Patient pays:** $340

#### 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:** $190
- **Coinsurance:** $0
- **Limits or exclusions:** $150
- **Total:** $340

### Managing type 2 diabetes (routine maintenance of a well controlled condition)
- **Amount owed to providers:** $5,400
- **Plan pays:** $4,290
- **Patient pays:** $1,110

#### 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:** $0
- **Copays:** $650
- **Coinsurance:** $380
- **Limits or exclusions:** $80
- **Total:** $1,110
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.