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 (73-860) 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.qualchoice.com , and view the Glossary at www.cciio.cms.gov . You can call 1-800-235-7111 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Calendar year accumulative deductible In-Network: Self $500 / Self + One or Self + Family $1,000 Out-of-Network: Self $1,000 / Self + One or Self + Family $3,000	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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. 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]	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 deductible for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Self $5,000 / Self + One or Self + Family $10,000 Out-of-Network: Self $13,200 / Self + One or Self + Family $26,400	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?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	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 www.qualchoice.com or call 1-800-235-7111 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 (only available under the Point-of-Service/POS benefit if enrolled in the High Option) 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		Network Provider (You will pay the least)	Out-of-Network 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	$20 Copayment / visit	40% Coinsurance	None
	Specialist visit	$35 Copayment / visit	40% Coinsurance	None
	Preventive care/screening/ immunization	Nothing	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance after deductible	40% Coinsurance after deductible	If you use out-of-network providers, the plan will pay nothing unless a preauthorization is obtained by you
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after deductible	40% Coinsurance after deductible	If you use out-of-network providers, the plan will pay nothing unless a preauthorization is obtained by you

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network 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 www.[insert].com	Generic drugs	$10 Copayment / prescription at retail, $0 Copayment / prescription at mail	Not Covered	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription) You pay three monthly copayment amounts for each 90 day mail order drug Mail order is not available for Specialty medications
	Preferred brand drugs	$40 Copayment / prescription at retail, $120 Copayment / prescription at mail	Not Covered	
	Non-preferred brand drugs	$60 Copayment / prescription at retail, $180 Copayment / prescription at mail	Not Covered	
	Specialty drugs	$100 Copayment / prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 Copayment / visit, No deductible	40% Coinsurance	If you use out-of-network providers, the plan will pay nothing unless a preauthorization is obtained by you
	Physician/surgeon fees	$100 Copayment / visit	40% Coinsurance	None
If you need immediate medical attention	Emergency room care	$150 Copayment / visit	$150 Copayment / visit	None
	Emergency medical transportation	$100 Copayment / trip for ground and $150 Copayment / trip for air/sea	$100 Copayment / trip for ground and $150 Copayment / trip for air/sea	None
	Urgent care	$35 Copayment / visit	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 Copayment / day	40% Coinsurance	Inpatient Hospital requires preauthorization; In-Network $500 Copayment maximum per admission.
	Physician/surgeon fees	$100 Copayment / No deductible	40% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network 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	$100 Copayment / visit	40% Coinsurance	Outpatient Hospital
	Inpatient services	$100 Copayment / visit	40% Coinsurance	Inpatient Hospital requires preauthorization; In-Network $500 Copayment Maximum per admission.
If you are pregnant	Office visits	Nothing	40% Coinsurance	$20 Copayment per office visit for all postnatal care after initial visit
	Childbirth/delivery professional services	Nothing	40% Coinsurance	None
	Childbirth/delivery facility services	Nothing	40% Coinsurance	Requires preauthorization
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after deductible	40% Coinsurance after deductible	Requires preauthorization; Coverage is limited to 40 visits per year
	Rehabilitation services	$20 Copayment / visit	40% Coinsurance	Coverage is limited to 60 visits or two consecutive months per condition for physical, or occupational, or a combination of both.
	Habilitation services	$20 Copayment / visit	40% Coinsurance	Coverage is limited to 60 visits or two consecutive months per condition for physical, or occupational or a combination of both.
	Skilled nursing care	$100 Copayment / day	40% Coinsurance	Requires preauthorization; In-Network $500 Copayment maximum per admission for Inpatient Rehabilitation Services/Skilled Nursing Care
	Durable medical equipment	20% Coinsurance after deductilble	40% Coinsurance after deductible	Call QualChoice at 1-800-235-7111 for assistance with rental or purchase
	Hospice services	Nothing	40% Coinsurance	
If your child needs dental or eye care	Children's eye exam	Nothing	40% Coinsurance	Covers a screening vision exam to determine the need for vision correction
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	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.)		
• Acupuncture • Cosmetic • Dental care (Adult)	• Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • 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.)		
• Bariatric Surgery • Chiropractic care	• Hearing aids, $1,400 / ear every 3 years • Infertility treatment	• Routine eye care (Adult)

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: [insert applicable contact information from instructions].

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 [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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 *copay*** **$35**
- **Hospital (facility) *copay*** **$100**
- **Other *copay*** **$100**

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	$500
Copayments	$235
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,395**

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 *copay*** **$35**
- **Hospital (facility) *copay*** **$100**
- **Other *copay*** **$100**

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	$500
Copayments	$235
Coinsurance	$60
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$855**

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

- **The plan's overall deductible** **$500**
- **Specialist *copay*** **$35**
- **Hospital (facility) *copay*** **$100**
- **Other *copay*** **$100**

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	$500
Copayments	$235
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$825**

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