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?	$ 0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	N/A	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?	In-Network: Self $5,500/Self + One or Self + Family $11,000	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 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 does not 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, 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
		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	Not Covered	None
	Specialist visit	$40 Copayment / visit	Not Covered	None
	Preventive care/screening/ immunization	Nothing	Not Covered	You may have to pay for services that aren't preventative. Ask your provider if the services you need are preventative. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Nothing	Not Covered	
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	Not Covered	Requires preauthorization
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, $15 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)	$200 Copayment / visit	Not Covered	None
	Physician/surgeon fees	$200 Copayment / visit	Not Covered	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	$100 Copayment / trip for ground and $150 Copayment / trip for air/sea	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)	
		Copayment / trip for air/sea		
	Urgent care	$40 Copayment / visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 Copayment / visit	Not Covered	Outpatient Hospital / visit
	Physician/surgeon fees	$200 Copayment / visit	Not Covered	Inpatient Hospital requires preauthorization, $1,000 Copayment maximum per admission
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$200 Copayment / visit	Not Covered	Outpatient Hospital / visit
	Inpatient services	$200 Copayment / visit	Not Covered	Inpatient Hospital requires preauthorization, $1,000 Copayment maximum per admission
If you are pregnant	Office visits	Nothing	Not Covered	$20 Copayment per office visit for all postnatal care after initial visit
	Childbirth/delivery professional services	Nothing	Not Covered	None
	Childbirth/delivery facility services	Nothing	Not Covered	None
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	Not Covered	Requires preauthorization. Coverage is limited to 40 visits per year
	Rehabilitation services	$20 Copayment / visit	Not Covered	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	Not Covered	Coverage is limited to 60 visits or two consecutive months, per condition for physical, or occupational, or a combination of both.
	Skilled nursing care	$200 Copayment / visit	Not Covered	Requires preauthorization, $1,000 Copayment maximum per admission for Inpatient Rehabilitation Services/Skilled Nursing Care
	Durable medical equipment	30% Coinsurance	Not Covered	Call QualChoice at 1-800-235-7111 for assistance with rental or purchase
	Hospice services	Nothing	Not Covered	
If your child needs dental or eye care	Children's eye exam	Nothing	Not Covered	Covers a screening vision exam to determine the need for vision correction

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)	
	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 surgery
- 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
- Infertility treatment
- Routine eye care (Adult)
- Hearing aids, $1,400 / ear every 3 years

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	**None**
Specialist *copay*	**$40**
Hospital (facility) *copay*	**$200**
Other *copay*	**$200**

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	$440
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$500**

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

The plan's overall deductible	**None**
Specialist *copay*	**$40**
Hospital (facility) copay	**$200**
Other *copay*	**$200**

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	$0
Copayments	$440
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$500**

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

The plan's overall deductible	**None**
Specialist *copay*	**$40**
Hospital (facility) *copay*	**$200**
Other *copay*	**$200**

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	$0
Copayments	$440
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$440**

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