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 71-015) 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.SambaPlans.com, and view the Glossary at www.SambaPlans.com/health-benefit-plan/sbc/. You can call 1-800-638-6589 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO: $300 / Self Only; $600 / Self Plus One or Self and Family Non-PPO: $300 / Self Only; $600 / Self Plus One or Self and Family	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. Prescription drugs, office visits, telehealth, and preventive care you receive from a PPO provider.	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?	PPO providers: $5,000 Self Only; $10,000 Self Plus One and Self & Family Non-PPO providers: $6,000 Self Only; $12,000 Self Plus One; $14,000 Self & Family	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?	Premiums, balance-billed charges, penalties for failure to get prior approval, and expenses 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.SambaPlans.com or call 1-800-638-6589 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	$15 copay per visit; deductible does not apply	35% coinsurance	
	Specialist visit	$25 copay per visit; deductible does not apply	35% coinsurance	No referral needed.
	Preventive care/screening/ immunization	No charge	35% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	35% coinsurance	Quest Lab & LabCorp covered services are paid at 100%.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	35% coinsurance	Prior authorization is required. If you do not get prior authorization, we will reduce our allowance by 20%.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.SambaPlans.com	Generic drugs	Retail: $10 copay Mail: $15 copay	Retail: $10 copay Mail: $15 copay	No deductible. For purchases made at a non-network pharmacy, you pay the same per prescription copayments/coinsurances, plus the difference in cost had you used an in-network pharmacy. Retail purchases are limited to initial fill, up to a 30-day supply, and one refill. Mail order is limited to a 90-day supply. A 90-day supply of maintenance drugs can be purchased at select participating retail pharmacies through Express Scripts Smart90® Program; see page 74 of the Plan brochure.
	Preferred brand drugs	Retail: 30% coinsurance, $100 max. Mail: 30% coinsurance, $200 max.	Retail: 30% coinsurance, $100 max. Mail: 30% coinsurance, $200 max.	
	Non-preferred brand drugs	Retail: 45% coinsurance, $300 max. Mail: 45% coinsurance, $400 max.	Retail: 45% coinsurance, $300 max. Mail: 45% coinsurance, $400 max.	
	Specialty drugs	Generic/Preferred: 30% coinsurance, $160 max. Non-Preferred: 45% coinsurance, $320 max.	Not covered	Limited to a 30-day supply. Requires prior authorization. Must be obtained through Accredo Specialty Pharmacy.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance; deductible does not apply	35% coinsurance	
	Physician/surgeon fees	15% coinsurance	35% coinsurance	Some services require prior authorization. If you do not get prior authorization, we will reduce our allowance by 20%.
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	Covered services rendered within 24 hours of an accidental injury are paid in full.
	Emergency medical transportation	15% coinsurance	35% coinsurance	
	Urgent care	15% coinsurance	35% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay per confinement Nothing for room & board; 15% coinsurance for other hospital charges	$300 copay per confinement 35% coinsurance for room & board and other hospital charges	Prior authorization is required; $500 penalty for failure to get prior approval.
	Physician/surgeon fees	15% coinsurance	35% coinsurance	Some services require prior authorization. If you do not get prior authorization, we will reduce our allowance by 20%.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 primary care copay; $25 specialist copay; 15% coinsurance for other services	35% coinsurance	
	Inpatient services	$200 copay per confinement Nothing for room & board; 15% coinsurance for other hospital charges	$300 copay per confinement 35% coinsurance for room & board and other hospital charges	Prior authorization is required; $500 penalty for failure to get prior approval.

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 are pregnant	Office visits	$15 primary care copay; $25 specialist copay	35% coinsurance	
	Childbirth/delivery professional services	15% coinsurance	35% coinsurance	
	Childbirth/delivery facility services	No charge	$300/confinement 35% coinsurance for room & board and other hospital charges	No prior authorization needed.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	50% coinsurance	Limited to 50 visits per calendar year.
	Rehabilitation services	15% coinsurance	Physical/occupational therapy: 50% coinsurance Speech therapy: 35% coinsurance	Physical/occupational therapy is limited to 80 visits per year. Speech therapy is limited to 50 visits per year.
	Habilitation services	15% coinsurance	Physical/occupational therapy: 50% coinsurance Speech therapy: 35% coinsurance	Physical/occupational therapy is limited to 80 visits per year. Speech therapy is limited to 50 visits per year.
	Skilled nursing care	15% coinsurance	35% coinsurance	Facility care limited to 45 days per year.
	Durable medical equipment	15% coinsurance	50% coinsurance	
	Hospice services	15% coinsurance	35% coinsurance	Inpatient care limited to 14 days per year. Outpatient care limited to $15,000.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Benefits are only available if treating an accidental injury or medical condition.
	Children's glasses	Not covered	Not covered	Benefits are only available if required as a direct result of an accidental injury or intraocular surgery.
	Children's dental check-up	Not covered	Not covered	Dental benefits are only available for treatment of accidental injury to sound natural teeth.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)		
• Cosmetic surgery (except for those procedures listed on pages 53 and 54 of the Plan brochure)	• Dental care (Adult) (except treatment of an accidental injury; page 83 of the Plan brochure)	• Infertility treatment (except as noted on page 40 of the Plan brochure)
• Long-term care (page 65 of the Plan brochure)	• Routine eye care (Adult) (page 45 of the Plan brochure)	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)		
• Acupuncture; limited to 26 visits per year (page 49 of the Plan brochure)	• Bariatric surgery (prior approval is required; see page 52 of the Plan brochure)	• Chiropractic care; limited to 30 manipulations per year (page 49 of the Plan brochure)
• Hearing aids; limited to $1,000 per ear for children & $500 per ear for adults every 3 years (page 45 of the Plan brochure)	• Non-emergency care when traveling outside the U.S. (page 85 of the Plan brochure)	• Private-duty nursing (page 48 of the Plan brochure)
• Routine foot care; (page 46 of the Plan brochure)	• Weight loss programs (pages 50 and 87 of the Plan brochure)	

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 1-800-638-6589 or visit www.opm.gov/healthcare-insurance/healthcare/. 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 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 FEHB Plan brochure. If you need assistance, you can contact: SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800 or call 1-800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155).

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 1-800-638-6589.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-638-6589.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-638-6589.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-638-6589.

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** **$300**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **15%**

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	$300
Copayments	$11
Coinsurance	$607
What isn't covered	
Limits or exclusions	$15
The total Peg would pay is	**$933**

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

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$229
Copayments	$235
Coinsurance	$1,180
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,644**

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

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$55
Coinsurance	$53
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$408**

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