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 ([insert brochure number]) 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.[insert], and view the Glossary at www.[insert]. You can call 1-800-[insert] to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 5,200 Self $ 10,400 Self Plus One $ 10,400 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.
Are there services covered before you meet your deductible?	Yes. Preventive Care Adults and Children; Well Woman 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$ 6,350 Self $ 12,700 Self Plus One $ 12,700 Family	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Balance – billed charges, 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?	No	The plan treats providers the same in determining payment for the same services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without permission from the plan.

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	Your Cost	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	50% Coinsurance	None
	Specialist visit	50% Coinsurance	None
	Preventive care/screening/ immunization	No Charge	A routine physical exam – one per person, per calendar year, deductible does not apply. Benefits for a range of preventive services recommended under Patient Protection and Affordable Care Act; as well as Well Woman benefits.
If you have a test	Diagnostic test (x-ray, blood work)	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	50% Coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	50% Coinsurance	None
	Preferred brand drugs	50% Coinsurance	None
	Non-preferred brand drugs	50% Coinsurance	None
	Specialty drugs	50% Coinsurance	None
	Medicines to promote better health under the Patient Protection and Affordable Care Act.	No Charge	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	None
	Physician/surgeon fees	50% Coinsurance	None
If you need immediate medical attention	Emergency room care	50% Coinsurance	None
	Emergency medical transportation	50% Coinsurance	None
	Urgent care	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% Coinsurance	None
	Physician/surgeon fees	50% Coinsurance	None

Common Medical Event	Services You May Need	Your Cost	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% Coinsurance	None
	Inpatient services	50% Coinsurance	None
If you are pregnant	Office visits	50% Coinsurance	None
	Childbirth/delivery professional services	50% Coinsurance	None
	Childbirth/delivery facility services	50% Coinsurance	None

Common Medical Event	Services You May Need	Your Cost	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	Not Covered	
	Rehabilitation services	50% Coinsurance	Limited to Occupational, Speech and Physical Therapy up to a combined 60 visits per calendar year.
	Habilitation services	Not Covered	No Coverage Habilitation Services
	Skilled nursing care	Not Covered	No Coverage Skilled Nursing Care
	Durable medical equipment	Not Covered	No Coverage Durable Medical Equipment
	Hospice services	Not Covered	No Coverage Hospice Service
If your child needs dental or eye care	Children's eye exam	Not Covered	No Coverage Eye Exams
	Children's glasses	Not Covered	No Coverage for Glasses
	Children's dental check-up	Not Covered	No Coverage Dental Check Ups

Excluded Services & Other Covered Services:

Services You Plan Generally Does NOT Cover (Check your plan's brochure for more information and a list of any other excluded services.)

- Home Health Care
- Durable Medical Equipment
- Glasses
- Bariatric Surgery
- Hearing Aids
- Habilitation Services
- Hospice Service
- Routine Dental Service
- Infertility Treatment
- Private Duty Nursing
- Skilled Nursing Care
- Routine Eye Exam
- Acupuncture
- Cosmetic Surgery
- Long-Term Care
- 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 brochure.)

- Well Woman Coverage
- Chiropractic Coverage

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 800-222-2798 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 or assistance, you can contact 800-222-2798.

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 800-222-2798
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-222-2798
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 800-222-2798
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-222-2798

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	**$5,200**
Specialist *[cost sharing]*	**50%**
Hospital (facility) *[cost sharing]*	**50%**
Other *[cost sharing]*	**50%**

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	$5.200
Copayments	$0
Coinsurance	$3,750
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$8,950**

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

The plan's overall deductible	**$5,200**
Specialist *[cost sharing]*	**50%**
Hospital (facility) *[cost sharing]*	**50%**
Other *[cost sharing]*	**50%**

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	$5,200
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$6,300**

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

The plan's overall deductible	**$5,200**
Specialist *[cost sharing]*	**50%**
Hospital (facility) *[cost sharing]*	**50%**
Other *[cost sharing]*	**50%**

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	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$1,900**

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