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. You can get the FEHB Plan brochure at www.SambaPlans.com or by calling 1-800-638-6589.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300**/person **$600**/family Does not apply to some services such as prescription drugs and preventive care you receive from an In-Network/PPO (Preferred) provider.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for certain covered services you use. **Copayments** and **coinsurance** amounts do not count toward your **deductible**, which generally starts over January 1st. When a covered service or supply is subject to a **deductible**, only the Plan allowance for the service or supply counts toward the **deductible**. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible** and for which services are subject to the **deductible**.
Are there other deductibles for specific services?	No	You do not have to meet **deductible** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For PPO providers: **$3,500** person/**$7,000** family. For Non-PPO & PPO providers combined: **$6,500** person/**$13,000** family. For Network retail pharmacies & Mail Order program: **$2,000** person/**$4,000** family	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 health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, penalties for failure to preauthorize/precertify, and expenses this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of In-Network/PPO providers visit www.SambaPlans.com or call 1-800-887-9735.	If you use an in-network doctor or other health care **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 in-network, PPO (Preferred), or participating for **providers** in our **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See this plan's FEHB brochure for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $20) you pay for covered health care, 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 10% would be $100. 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	30% coinsurance	No deductible when services are rendered by an In-Network/PPO provider.
	Specialist visit	$20/visit	30% coinsurance	
	Other practitioner office visit	10% coinsurance	30% coinsurance	Acupuncture and chiropractic manipulations are limited to 26 visits per person, per calendar year.
	Preventive care/screening/ immunization	No charge	30% coinsurance	No deductible when services are rendered by an In-Network/PPO provider.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Quest Labs & LabCorp outpatient services are paid at 100%. See page 28 of the Plan brochure.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Precertification is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
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: $8/prescription Mail: $12/prescription	Retail: $8/prescription Mail: $12/prescription Plus difference in cost had you used an in-network pharmacy	No deductible. Retail purchases are limited to initial fill (up to 30-day supply) and one refill. Mail order is limited to a 90-day supply A 90-supply of maintenance drugs can be purchased at a CVS retail pharmacy; see page 66 of the Plan brochure.
	Preferred brand drugs	Retail: 20% ($40 min./ $55 max.) Mail: 20% ($80 min./$110 max.)	Retail: 20% ($40 min./$55 max.) Mail: 20% ($80 min./$110 max.) Plus difference in cost had you used an in-network pharmacy	
	Non-preferred brand drugs	Retail: 35% ($60 min./ $100 max.) Mail: 35% ($120 min./ $225 max.)	Retail: 35% ($60 min./ $100 max.) Mail: 35% ($120 min./ $225 max.) Plus difference in cost had you used an in-network pharmacy	
	Specialty drugs	$80/30-day supply; $160/60-day supply; $240/90-day supply	Specialty drugs must be obtained through the CVS Caremark Pharmacy system	Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	No deductible when services are rendered by an In-Network/PPO facility.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Some services require preauthorization.
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	Covered services rendered within 72 hours of an accidental injury are paid in full; see page 61 of the Plan brochure.
	Emergency medical transportation	10% coinsurance	30% coinsurance	
	Urgent care	10% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copayment per confinement Nothing for room & board; 10% for other hospital charges	$300 copayment per confinement 30% for room & board and other hospital charges	Preauthorization is required; $500 penalty for failure to preauthorize.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	Some services require preauthorization
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copayment/visit for office visits 10% coinsurance other outpatient services	30% coinsurance	none
	Mental/Behavioral health inpatient services	$200 copayment per confinement Nothing for room & board; 10% for other hospital charges	$300 copayment per confinement 30% for room & board and other hospital charges	Preauthorization is required; $500 penalty for failure to preauthorize.
	Substance use disorder outpatient services	$20 copayment/visit for office visits 10% coinsurance other outpatient services	30% coinsurance	none
	Substance use disorder inpatient services	$200 copayment per confinement Nothing for room & board; 10% for other hospital charges	$300 copayment per confinement 30% for room & board and other hospital charges	Preauthorization is required; $500 penalty for failure to preauthorize.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance	none
	Delivery and all inpatient services	Hospital: Nothing Doctor: 10% coinsurance	Per confinement: $300 copayment; plus 30% coinsurance	none

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Private duty nursing care limited to 50 visits per year; home health aides are not covered. Preauthorization is required.
	Rehabilitation services	10% coinsurance	50% coinsurance/physical & occupational therapy 30% coinsurance/speech therapy	Physical/occupational therapy limited to 75 visits per year Speech therapy requires preauthorization and is limited to 50 visits per year
	Habilitation services	10% coinsurance	50% coinsurance/physical & occupational therapy 30% coinsurance/speech therapy	
	Skilled nursing care	10% coinsurance	30% coinsurance	Skilled nursing care facility limited to 10 days per confinement
	Durable medical equipment	10% coinsurance	50% coinsurance	Preauthorization is required.
	Hospice service	10% coinsurance	30% coinsurance	Inpatient care limited to 14 days per year Outpatient care limited to $15,000
If your child needs dental or eye care	Eye exam	All charges	All charges	Benefits are only available if treating an accidental injury or medical condition; see page 39 of the Plan brochure
	Glasses	All charges	All charges	Benefits are only available if required as a direct result of an accidental injury or intraocular surgery; see page 39 of the Plan brochure
	Dental check-up	All charges	All charges	Excluded

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 (except to treat a congenital anomaly, an accidental injury or illness, or breast reconstruction following a mastectomy; page 48 of the Plan brochure)
- Dental care (Adult) (except treatment of an accidental injury to sound natural teeth; page 73 of the Plan brochure)
- Infertility treatment (except as noted on page 34 of the Plan brochure)
- Long-term care (page 58 of the Plan brochure)
- Routine eye care (Adult) (page 39 of the Plan brochure)

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 (page 43 of the Plan brochure)
- Diabetic foot care (page 40 of the Plan brochure)
- Chiropractic care (page 43 of the Plan brochure)
- Hearing aids (page 39 of the Plan brochure)
- Outpatient private duty nursing (page 42 of the Plan brochure)
- Covered services rendered outside the U.S. (page 75 of the Plan brochure)
- Weight loss programs (when prescribed by a physician and rendered by a covered provider; page 44 of the Plan brochure)
- Bariatric surgery (prior approval is required; see page 46 of the Plan brochure)

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, to convert to an individual policy, 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. An individual policy may also provide different benefits than you had 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 1-1800-638-6589 or visit www.opm.gov.insure/health.

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: SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800 or call 1-800-638-6589 or 301-984-1440 (for TDD, use 301-984-4155).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care 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 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 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 they are 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** $6,370
- **Patient pays** $1,170

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	$300
Copays	$210
Coinsurance	$510
Limits or exclusions	$150
Total	**$1,170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,620
- **Patient pays** $1,780

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	$300
Copays	$330
Coinsurance	$1,110
Limits or exclusions	$40
Total	**$1,780**

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.

Questions: Call 1-800-638-6589 or visit us at www.SambaPlans.com.
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.SambaPlans.com or call 1-800-638-6589 to request a copy.