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 providers: $350/Self Only; $700/Self Plus One; $900/Self and Family Non-PPO providers: $350/Self Only; $700/ Self Plus One; $900/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, inpatient hospital 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: $7,000 Self Only; $14,000 Self Plus One and Self & Family Non-PPO providers: $9,500 Self Only; $19,000 Self Plus One and 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	$20 copay/visit; deductible does not apply	45% coinsurance	
	Specialist visit	$30 copay/visit; deductible does not apply	45% coinsurance	No referral is needed.
	Preventive care/screening/ immunization	No charge	45% 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)	20% coinsurance	45% coinsurance	Quest Labs & LabCorp outpatient services are paid at 100%.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	45% 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: $12 copay ($7 copay if Medicare Part B primary) Mail: $20 copay ($15 copay if Medicare Part B primary)	Retail: $12 copay ($7 copay if Medicare Part B primary) Mail: $20 copay ($15 copay if Medicare Part B primary) Plus the difference in cost had you used an in-network pharmacy	No deductible 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: 35% coinsurance (30% coinsurance if Medicare Part B primary), $150 max. Mail: 35% coinsurance (30% coinsurance if Medicare Part B primary), $300 max.	Retail: 35% coinsurance (30% coinsurance if Medicare Part B primary), $150 max. Mail: 35% coinsurance (30% coinsurance if Medicare Part B primary), $300 max. Plus the difference in cost had you used an in-network 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)	
	Non-preferred brand drugs	Retail: 50% coinsurance, $300 max. Mail: 50% coinsurance, $600 max.	Retail: 50% coinsurance, $300 max. Mail: 50% coinsurance, $600 max. Plus difference in cost had you used an in-network pharmacy	
	Specialty drugs	Generic/Preferred: 35% coinsurance, $240 max. Non-Preferred: 50% coinsurance, $480 max.	Not covered	Limited to a 30-day supply. Requires prior authorization. Must be obtained through Accredo.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	45% coinsurance	
	Physician/surgeon fees	20% coinsurance	45% 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	20% coinsurance	20% coinsurance	Covered services rendered within 24 hours of an accidental injury are paid in full.
	Emergency medical transportation	20% coinsurance	45% coinsurance	
	Urgent care	20% coinsurance	45% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/confinement Nothing for room & board; 20% coinsurance for other hospital charges	$400 copay/confinement 45% coinsurance for room & board and other hospital charges	Prior authorization is required; $500 penalty for failure to get prior approval.
	Physician/surgeon fees	20% coinsurance	45% coinsurance	Some services require prior authorization. If you do not get prior authorization, we will reduce our allowance by 20%.

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	$30 copay/office visit 20% coinsurance for other services	45% coinsurance	Some services require prior authorization. If you do not get prior authorization, we will reduce our allowance by 20%.
	Inpatient services	$200 copay/confinement Nothing for room & board; 20% coinsurance for other hospital charges	$400 copay/confinement 45% coinsurance for room & board and other hospital charges	Prior authorization is required; $500 penalty for failure to get prior approval.
If you are pregnant	Office visits	$30 copay/visit	45% coinsurance	
	Childbirth/delivery professional services	No charge	45% coinsurance	
	Childbirth/delivery facility services	No charge	$400 copay/confinement 45% 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	20% coinsurance	50% coinsurance	Limited to 25 visits per calendar year.
	Rehabilitation services	20% coinsurance	Physical/occupational therapy: 50% coinsurance Speech therapy: 45% coinsurance	Physical/occupational therapy limited to 50 visits per year Speech therapy requires prior authorization and is limited to 30 visits per year
	Habilitation services	20% coinsurance	Physical/occupational therapy: 50% coinsurance Speech therapy: 45% coinsurance	Physical/occupational therapy limited to 50 visits per year Speech therapy requires prior authorization and is limited to 30 visits per year
	Skilled nursing care	20% coinsurance	45% coinsurance	Facility care limited to 30 days per year
	Durable medical equipment	20% coinsurance	50% coinsurance	
	Hospice services	20% coinsurance	45% coinsurance	Inpatient care limited to 14 days per year Outpatient care limited to $15,000

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 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 plan's FEHB brochure for more information and a list of any other excluded services.)

- Cosmetic surgery (except for those procedures listed on pages 52 and 53 of the Plan brochure)
- Dental care (Adult) (except treatment of an accidental injury to sound natural teeth; page 82 of the Plan brochure)
- Infertility treatment (except as noted on page 39 of the Plan brochure)
- Long-term care (page 64 of the Plan brochure)
- Routine eye care (Adult) (page 44 of the Plan brochure)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)

- Acupuncture; limited to 26 visits per year (page 48 of the Plan brochure)
- Bariatric surgery (prior approval is required; see page 51 of the Plan brochure)
- Chiropractic care; limited to 12 manipulations per year (page 48 of the Plan brochure)
- Hearing aids; limited to $1,000 per ear for children & $500 per ear for adults every 3 years (pages 43 and 44 of the Plan brochure)
- Non-emergency care when traveling outside the U.S. (page 84 of the Plan brochure)
- Private-duty nursing (prior authorization is required; see page 47 of the Plan brochure)
- Routine foot care; (pages 44 and 45 of the Plan brochure)
- Weight loss programs (when prescribed by a physician and rendered by a covered provider; page 49 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.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: 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 plan provide Minimum Essential Coverage? Yes

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	$350
Specialist copayment	$30
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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	$36
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11
The total Peg would pay is	$47

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

The plan's overall deductible	$350
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$350
Copayments	$320
Coinsurance	$1,946
What isn't covered	
Limits or exclusions	$34
The total Joe would pay is	$2,650

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

The plan's overall deductible	$350
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$350
Copayments	$60
Coinsurance	$9
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$419

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