This is only a summary. If Please read the FEHB Plan brochure (RI 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. You can get the FEHB Plan brochure at www.qualchoice.com or by calling 1 (800) 235-7111.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** 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. In-Network: Self $**5,500**/ Self + One or Self + Family **$11,000**	The **maximum out-of-pocket limit** is the most you could pay during a coverage period (usually one 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 maximum out–of–pocket limit?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **maximum 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 providers**, see www.qualchoice.com or call 1 (800) 235-7111.	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. Plans use the term in-network, **preferred**, or participating for **providers** in their **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 don't need a referral to see an **in-network specialist**.	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 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) 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 20% would be $200. 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 in network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Co-payment	Not Covered	——————none——————
	Specialist visit	$40 Co-payment	Not Covered	——————none——————
	Other practitioner office visit	30% Coinsurance	Not Covered	Chiropractic care is limited to 20 visits per CY. Therapies are limited to 60 visits per CY
	Preventive care/screening/immunization	No Cost	Not Covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No cost	Not Covered	Genetic Testing 30% coinsurance
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	Not Covered	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.qualchoice.com .	Generic drugs	$10 Co-payment at retail, $15 Co-payment 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 Co-payment at retail, $120 Co-payment at mail	Not Covered	
	Non-preferred brand drugs	$60 Co-payment at retail, $180 Co-payment at mail	Not Covered	
	Specialty drugs	$100 Co-payment	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center or observation)	$200 Co-payment	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Physician/surgeon fees	$200 Co-payment	Not Covered	——————none——————
If you need immediate medical attention	Emergency room services/Observation services	$150 Co-payment	$150 Co-payment	——————none——————
	Emergency medical transportation	$100 Co-payment for ground/$150 Co-payment for air/sea	$100 Co-payment for ground/$150 Co-payment for air/sea	$10,000 per trip limit for air/sea ambulance
	Urgent care	$40 Co-payment	$40 Co-payment	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 Co-payment per day	Not Covered	In Network Copayment maximum per admission is $1000
	Physician/surgeon fee	$200 Co-payment	Not Covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 Co-payment per office visit and $200 Co-payment per outpatient visit	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	$200 Co-payment per day	Not Covered	In Network Copayment maximum per admission is $1,000
	Substance use disorder outpatient services	$20 Co-payment per office visit and $200 Co-payment per outpatient visit	Not Covered	——————none——————
	Substance use disorder inpatient services	$200 Co-payment per day	Not Covered	In Network Copayment maximum per admission is $1,000
If you are pregnant	Prenatal and postnatal care	No cost	Not Covered	$20 per office visit for all postnatal visits after first one
	Delivery and all inpatient services	No cost	Not Covered	——————none——————
If you need help	Home health care	30% Coinsurance	Not Covered	40 visit limit per CY

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
recovering or have other special health needs	Rehabilitation services	$40 Co-payment	Not Covered	60 visit limit per CY or 2 consecutive months. Cardiac rehab requires pre-authorization
	Habilitation services	$40 Co-payment	Not Covered	60 visit limit per CY or 2 consecutive months
	Skilled nursing care	$200 Co-payment per day	Not Covered	In Network Copayment maximum per admission is $1,000
	Durable medical equipment	20% Coinsurance	Not Covered	Call Qualchoice at 1-800-235-7111 for assistance with rental or purchase
	Hospice service	No cost	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	$40 Co-payment	Not Covered	Covers a screening vision exam to determine the need for vision correction
	Glasses	30% Coinsurance	Not Covered	Covers one pair of glasses for accidental injury to eyes
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult) except for Routine dental services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric Surgery • Chiropractic Care	• Hearing aids, 1 per ear every 3 years • Infertility Treatment	• Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may 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. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1 (800) 235-7111**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. You can contact your plan at **1 (800) 235-7111**. You can contact the Department of Labor's Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa/healthreform**. For questions about your rights, this notice, or assistance, you can contact your state insurance department at **1-800-852-5494**. Additionally, a consumer assistance program can help you file your appeal. Contact **1-800-852-5494**.

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." **This plan or policy <u>does provide</u> 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). **This health coverage <u>does meet</u> the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-235-7017**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-235-7017**.
Chinese (中文): 如果需要中文的帮助, **请拨打这个号码 1-800-235-7017**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-235-7017**.

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** $5,940
- **Patient pays** $1,600

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	$0
Copays	$300
Coinsurance	$1,100
Limits or exclusions	$200
Total	**$1,600**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,920
- **Patient pays** $1,480

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	$0
Copays	$1,000
Coinsurance	$400
Limits or exclusions	$80
Total	**$1,480**

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.