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 73-871) 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 and view the Glossary at feds.humana.com. You can call 1-800-448-6262 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0 /Self Only $ 0 /Self Plus One $ 0 /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.
Are there services covered before you meet your deductible?	The plan does not have a deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	$ 8,150/Self Only $ 16,300/Self Plus One $ 16,300/Self and 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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), and healthcare 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 feds.humana.com or call 1-800-448-6262 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	$50 copay/visit	Not covered	----------NONE----------
	Specialist visit	$70 copay/visit	Not covered	----------NONE----------
	Preventive care/screening/ immunization	No charge	Not covered	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)	PCP: $50 copay/visit Spec: $70 copay/visit	Not covered	----------NONE----------
	Imaging (CT/PET scans, MRIs)	PCP: $50 copay/visit Spec: $70 copay/visit	Not covered	----------NONE----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at feds.humana.com	Generic drugs – Level One	$10 copay retail / $25 copay mail	Not covered	Covers up to a 30 day supply; 31-90 day supply (mail order Rx)
	Non-Preferred generic drugs – Level Two	$45 copay retail / $112.50 copay mail	Not covered	Covers up to a 30 day supply; 31-90 day supply (mail order Rx)
	Preferred brand drugs – Level Three	$65 copay retail / $162.50 copay mail	Not covered	Covers up to a 30 day supply; 31-90 day supply (mail order Rx)
	Non-Preferred brand /non-preferred higher cost generic – Level Four	$100 copay retail / $250 copay mail	Not covered	Covers up to a 30 day supply; 31-90 day supply (mail order Rx)
	Specialty drugs – Level Five	25% co-insurance	Not covered	May covers up to a 30-day supply (retail or mail order).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$700 copay/visit	Not covered	----------NONE----------
	Physician/surgeon fees	No charge	Not covered	----------NONE----------
If you need immediate medical attention	Emergency room care	$325 copay/visit	$325 copay/visit	----------NONE----------
	Emergency medical transportation	$50 copay	$50 copay	----------NONE----------
	Urgent care	$70 copay/visit	$70 copay/visit	----------NONE----------

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 a hospital stay	Facility fee (e.g., hospital room)	$900/day for first 3 days per admission	Not covered	----------NONE----------
	Physician/surgeon fees	No charge	Not covered	----------NONE----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay/visit	Not covered	----------NONE----------
	Inpatient services	$900/day for first 3 days per admission	Not covered	----------NONE----------
If you are pregnant	Office visits	No charge	Not covered	----------NONE----------
	Childbirth/delivery professional services	Covered under the facility copay	Not covered	----------NONE----------
	Childbirth/delivery facility services	$900/day for first 3 days per admission	Not covered	----------NONE----------
If you need help recovering or have other special health needs	Home health care	$70 copay/visit	Not covered	----------NONE----------
	Rehabilitation services	$70 copay/visit (PT, OT, and Speech therapy)	Not covered	60 visits/year per condition for each service
	Habilitation services	$70 copay visit	Not covered	60 visits/year
	Skilled nursing care	$900/day for first 3 days per admission	Not covered	100 days/year
	Durable medical equipment	50% coinsurance	Not covered	Pre-auth for DME over $750
	Hospice services	No charge	Not covered	----------NONE----------
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Thru age 17
	Children's glasses	Not covered	Not covered	----------NONE----------
	Children's dental check-up	Not covered	Not covered	----------NONE----------

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
- Dental Care (Adult)
- Hearing Aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care
- Weight loss program

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)		
• Acupuncture • Bariatric Surgery	• Chiropractic Care • Infertility Treatment	• Routine eye care (Adult)

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 1-800-448-6262 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 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 us 1-800-448-6262.

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 1-800-448-6262.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-448-6262.]
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-800-448-6262.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-448-6262.]

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** **$0**
- **Specialist copayment** **$70**
- **Hospital (facility) copayment** **$900**
- **Other coinsurance** **0%**

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	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,820**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$70**
- **Hospital (facility) copayment** **$900**
- **Other coinsurance** **0%**

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	$0
Copayments	$2,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,100**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$70**
- **Hospital (facility) copayment** **$900**
- **Other coinsurance** **0%**

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

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