



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 73-829) 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](https://feds.humana.com). You can call 800-448-6262 to request a copy of either document.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$ <u>1,500</u> /Self Only \$ <u>3,000</u> /Self Plus One \$ <u>3,000</u> /Self and Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. <u>Copayments</u> and <u>coinsurance</u> amounts do not count toward your <u>deductible</u> , which generally starts over January 1. When a covered service/supply is subject to a <u>deductible</u> , only the <u>Plan</u> allowance for the service/supply counts toward the <u>deductible</u> . If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive care</u> and <u>prescription drug copayments</u> do not apply to <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductible</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For participating <u>providers</u> : \$8,150 Self Only/\$16,300 Self Plus One or Self and Family; For non-participating <u>providers</u> : \$16,300 Self Only/\$32,600 Self Plus One or Self and Family	The <u>out-of-pocket limit</u> , or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limit</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges (unless <u>balance-billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="https://feds.humana.com">feds.humana.com</a> or call 800-448-6262 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.



Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$50 <u>copay</u> /visit	50% of <u>plan</u> allowance after <u>deductible</u>	None
	<u>Specialist</u> visit	\$70 <u>copay</u> /visit	50% of <u>plan</u> allowance after <u>deductible</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	50% of <u>plan</u> allowance after <u>deductible</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% of <u>plan</u> allowance after <u>deductible</u>	Participating <u>provider</u> : 20% <u>coinsurance</u> in an inpatient or outpatient hospital setting
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% of <u>plan</u> allowance after <u>deductible</u>	Participating <u>provider</u> : 20% <u>coinsurance</u> in an inpatient or outpatient hospital setting
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="https://feds.humana.com/">https://feds.humana.com/</a> .	Generic drugs – Level One	\$10 <u>copay</u> retail / \$25 <u>copay</u> mail	50% of charges plus <u>copay</u>	Covers up to a 30 day supply; 31-90 day supply (mail order Rx)
	Non-Preferred generic drugs – Level Two	\$45 <u>copay</u> retail / \$112.50 <u>copay</u> mail	50% of charges plus <u>copay</u>	Covers up to a 30 day supply; 31-90 day supply (mail order Rx)
	Preferred brand drugs – Level Three	\$65 <u>copay</u> retail / \$162.50 <u>copay</u> mail	50% of charges plus <u>copay</u>	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 <u>copay</u> retail / \$250 <u>copay</u> mail	50% of charges plus <u>copay</u>	Covers up to a 30 day supply; 31-90 day supply (mail order Rx)
	<u>Specialty drugs</u> – Level Five	25% <u>coinsurance</u>	50% of charges plus <u>copay</u>	May cover up to a 30-day supply (retail or mail order).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% of <u>plan</u> allowance after <u>deductible</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	50% of <u>plan</u> allowance after <u>deductible</u>	None
If you need immediate medical attention	Emergency room care	\$350 <u>copay</u> after <u>deductible</u> /visit	\$350 copay after deduct./visit	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most, plus you may be balance billed)	
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$70 <u>copay</u> /visit	\$70 copay/visit	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% of <u>plan</u> allowance after <u>deductible</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	50% of <u>plan</u> allowance after <u>deductible</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>	50% of <u>plan</u> allowance after <u>deductible</u>	None
	Inpatient services	20% <u>coinsurance</u>	50% of <u>plan</u> allowance after <u>deductible</u>	None
<b>If you are pregnant</b>	Office visits	No charge	50% of <u>plan</u> allowance after <u>deductible</u>	None
	Childbirth/delivery professional services	No charge	50% of <u>plan</u> allowance after <u>deductible</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u> after <u>deductible</u>	50% of <u>plan</u> allowance after <u>deductible</u>	None
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	50% of <u>plan</u> allowance after <u>deductible</u>	None
	<u>Rehabilitation services</u>	\$70 <u>copay</u> after <u>deductible</u> (PT, OT, and Speech therapy)	50% of <u>plan</u> allowance after <u>deductible</u>	60 visits/year per condition for each service
	<u>Habilitation services</u>	\$70 <u>copay</u> after <u>deductible</u>	50% of <u>plan</u> allowance after <u>deductible</u>	60 visits/year
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% of <u>plan</u> allowance after <u>deductible</u>	60 days/year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% of <u>plan</u> allowance after <u>deductible</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% of <u>plan</u> allowance after <u>deductible</u>	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	50% of <u>plan</u> allowance after <u>deductible</u>	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 eye care (Adult)
- 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

**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 800-448-6262 or visit [www.opm.gov/healthcare-insurance/healthcare/](http://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](http://www.HealthCare.gov) or call 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 at 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 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 800-448-6262.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-448-6262.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800-448-6262.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 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 <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$70
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$10
Coinsurance	\$1,600
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,170</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$70
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$2,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,220</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$70
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$800
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,350</b>