




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 73-820) 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 800-314-3121 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$ <u>0</u> /Self Only \$ <u>0</u> /Self Plus One \$ <u>0</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> .
Are there services covered before you meet your <u>deductible</u>?	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.
Are there other <u>deductibles</u> for specific services?	Yes. \$ <u>100</u> /Self Only \$ <u>300</u> /Self Plus One \$ <u>300</u> /Self and Family For Out of Network coverage	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For network <u>providers</u> : \$5,000 Self Only/\$10,000 Self Plus One or Self and Family; For out-of-network <u>providers</u> : \$5,000 Self Only/\$10,000 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.
What is not included in the <u>out-of-pocket limit</u>?	<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> .
Will you pay less if you use a <u>network provider</u>?	Yes. See feds.humana.com or call 800-314-3121 for a list of <u>network providers</u> .	You pay the least if you use a <u>Plan provider</u> directed by your primary care provider (PCP). You pay more if you use a <u>Plan provider</u> not directed by your PCP. You will pay the most if you use a non <u>Plan 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 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
		Your Cost If You Use a PCP-directed In-network Provider	Your Cost If You Self-direct to an In-network Provider	Your Cost If You Use an Out-of-network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$5 <u>copay</u> /visit	\$10/visit	Reimbursed at contracted fee	None
	<u>Specialist</u> visit	\$5 <u>copay</u> /visit	\$10/visit	Reimbursed at contracted fee	None
	<u>Preventive care/screening/immunization</u>	No charge	No charge	Covered under the OV <u>copay</u>	You may have to pay for services that aren't preventive. Ask your provider 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)	No charge	No charge	25% of covered services	None
	Imaging (CT/PET scans, MRIs)	No charge	No charge	25% of covered services	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://feds.humana.com/ .	Generic drugs – Level One	\$5 <u>copay</u> /retail \$10 <u>copay</u> /mail	\$5 <u>copay</u> /retail \$10 <u>copay</u> /mail	Not covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail order).
	Preferred brand drugs – Level Two	\$15 <u>copay</u> /retail \$30 <u>copay</u> /mail	\$15 <u>copay</u> /retail \$30 <u>copay</u> /mail	Not covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail order). .
	Non-preferred brand drugs – Level Three	\$25 <u>copay</u> /retail \$50 <u>copay</u> /mail	\$25 <u>copay</u> /retail \$50 <u>copay</u> /mail	Not covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail order).
	<u>Specialty drugs</u> – Level Four	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	Covers up to a 30-day supply (retail or mail order).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost If You Use a PCP-directed In-network Provider	Your Cost If You Self-direct to an In-network Provider	Your Cost If You Use an Out-of-network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$25 <u>copay</u> /visit	\$25 <u>copay</u> /visit	Reimbursed at contracted fee	None
	Physician/surgeon fees	\$5 <u>copay</u> /visit	25% <u>coinsurance</u>	Reimbursed at contracted fee	None
If you need immediate medical attention	Emergency room care	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	
	<u>Emergency medical transportation</u>	\$25 <u>copay</u> /visit	\$25 <u>copay</u> /visit	\$25 <u>copay</u> /visit	Air ambulance - \$50 copay.
	<u>Urgent care</u>	\$25 <u>copay</u> /visit	\$25 <u>copay</u> /visit	\$25 <u>copay</u> /visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$50 <u>copay</u> / admission	Reimbursed at contracted fee	Pre-authorization required.
	Physician/surgeon fees	No charge	25% <u>coinsurance</u>	Reimbursed at contracted fee	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	Reimbursed at contracted fee	None
	Inpatient services	No charge	\$50 <u>copay</u> / admission	Reimbursed at contracted fee	None
If you are pregnant	Office visits	No charge	\$10 <u>copay</u> /visit	Reimbursed at contracted fee	None
	Childbirth/delivery professional services	No charge	No charge	Reimbursed at contracted fee	None
	Childbirth/delivery facility services	No charge	\$50 <u>copay</u> / admission	Reimbursed at contracted fee	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	25% <u>coinsurance</u>	Reimbursed at contracted fee	Authorization must be renewed after 60 days.
	<u>Rehabilitation services</u>	No charge	25% <u>coinsurance</u>	Reimbursed at contracted fee	60 visits/year per condition for each service.
	<u>Habilitation services</u>	No charge	\$10 <u>copay</u> /visit	Reimbursed at contracted fee	60 visits/year per condition

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost If You Use a PCP-directed In-network Provider	Your Cost If You Self-direct to an In-network Provider	Your Cost If You Use an Out-of-network Provider	
	<u>Skilled nursing care</u>	No charge	\$25 <u>copay</u> / admission	Reimbursed at contracted fee	Up to 30 days during member's lifetime.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Reimbursed at contracted fee	Pre-authorization is required for DME over \$750.
	<u>Hospice services</u>	No charge	25% <u>coinsurance</u>	Reimbursed at contracted fee	Maximum limit of 180 days. Pre-authorization is required.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Reimbursed at contracted fee	Until age 17.
	Children's glasses	Not covered	Not covered	Not covered	None---
	Children's dental check-up	Not covered	Not covered	Not covered	None---

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your <u>plan's</u> FEHB brochure for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic Surgery Dental Care (Adult) 	<ul style="list-style-type: none"> Hearing Aids Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Private duty nursing Routine foot care Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan's</u> FEHB brochure.)		
<ul style="list-style-type: none"> Bariatric Surgery Chiropractic Care 	<ul style="list-style-type: none"> Infertility Treatment 	<ul style="list-style-type: none"> 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 800-314-3121 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 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 800-314-3121.

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 800-314-3121.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-314-3121.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码800-314-3121.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-314-3121.]

—————*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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$5
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	50%

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	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$70

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$5
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	50%

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	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$620

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$5
■ Hospital (facility) <u>payment</u>	\$50
■ Other <u>coinsurance</u>	50%

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	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$200