



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-73-010) 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.hmsa.com/federalplan, and view the Glossary at www.hmsa.com/federalplan/SBCuniformglossary. You can call 1-800-776-4672 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$ 0 / Self Only \$ 0 / Self Plus One \$ 0 / Self and Family	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes. Some examples are <u>preventive care</u> , <u>telehealth</u> services, <u>maternity care</u> , and <u>family planning</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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$3,000 Self Only \$6,000 Self Plus One (\$3,000 per covered individual) \$9,000 Self and Family (\$3,000 per covered individual)	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 limits</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-billed</u> charges, 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 www.hmsa.com/federalplan or call 1-800-776-4672 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.

Important Questions	Answers	Why This Matters:
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> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> / visit	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$15 <u>copay</u> / visit	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u>	Physical Exams / Mammography (<u>screening</u>) / Immunizations 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)	X-ray: 20% <u>coinsurance</u> Blood Work: No charge	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Services may require <u>prior approval</u>
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://www.hmsa.com/federalplan	Generic drugs	\$7 <u>copay</u> / prescription (retail) \$0 <u>copay</u> / prescription (mail order)	\$7 <u>copay</u> plus 20% <u>coinsurance</u> / prescription (retail)	30-day supply limit for retail benefits 90-day supply limit for mail order benefits
	Preferred brand drugs	\$35 <u>copay</u> / prescription (retail) \$75 <u>copay</u> / prescription (mail order)	\$35 <u>copay</u> plus 20% <u>coinsurance</u> / prescription (retail)	30-day supply limit for retail benefits 90-day supply limit for mail order benefits
	Non-preferred brand drugs	\$70 <u>copay</u> / prescription (retail) \$185 <u>copay</u> / prescription (mail order)	\$70 <u>copay</u> plus 20% <u>coinsurance</u> / prescription (retail)	30-day supply limit for retail benefits 90-day supply limit for mail order benefits

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)	
	<u>Specialty drugs</u>	Preferred <u>Specialty Drug</u> \$80 <u>copay</u> / prescription (<u>plan provider</u>) Non-Preferred <u>Specialty Drug</u> \$200 <u>copay</u> / prescription (<u>plan provider</u>)	Not covered	30-day supply limit at a participating <u>plan provider</u>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% <u>coinsurance</u>	None
	Physician/surgeon fees	Physician: \$15 <u>copay</u> / visit Surgeon fees: No charge	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	Emergency Room Facility: 20% <u>coinsurance</u> Physician: \$15 <u>copay</u>	Emergency Room Facility: 20% <u>coinsurance</u> Physician: \$15 <u>copay</u>	None
	<u>Emergency medical transportation</u>	No charge (ground ambulance)	No charge (ground ambulance)	None
	<u>Urgent care</u>	\$15 <u>copay</u> / visit	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 per admission	30% <u>coinsurance</u>	The <u>allowed amount</u> is based on semi-private room rate
	Physician/surgeon fees	Physician: \$15 <u>copay</u> / visit Surgeon fees: No charge	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	30% <u>coinsurance</u>	None
	Inpatient services	\$200 per admission	30% <u>coinsurance</u>	The <u>allowed amount</u> is based on semi-private room rate
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u>	None
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	None
	Childbirth/delivery facility services	\$200 per admission	30% <u>coinsurance</u>	The <u>allowed amount</u> is based on semi-private room rate
	<u>Home health care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	150 visit limit per calendar year

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 help recovering or have other special health needs	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Services may require <u>prior approval</u>
	<u>Habilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Services may require <u>prior approval</u>
	<u>Skilled nursing care</u>	No charge	30% <u>coinsurance</u>	100 days limit per calendar year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Services may require <u>prior approval</u>
	<u>Hospice services</u>	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	20% <u>coinsurance</u>	30% <u>coinsurance</u>	One exam per year limit
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charge	30% <u>coinsurance</u>	One exam per year limit

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> .)			
• Acupuncture	• Cosmetic Surgery	• Private Duty Nursing	
• Cardiac Rehabilitation (except as offered through an HMSA program)	• Glasses (except for certain medical conditions)	• Weight loss programs not offered through HMSA	
	• Long-term Care		
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan's</u> FEHB brochure.)			
• Bariatric Surgery	• Hearing Aids	• Routine Eye Care (Adult)	
• Chiropractic Care	• Infertility Treatment	• Routine Foot Care	
• Dental Care (Adult)	• Non-emergency care when traveling outside the U.S.		

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 1-800-776-4672 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 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 FEHB Plan brochure. If you need assistance, you can contact: HMSA, Member Advocacy and Appeals. P.O. Box 1958, Honolulu, Hawaii 96805-1958 or call us at 808-948-5090 or toll-free at 1-800-462-2085.

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 1-800-776-4672.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-776-4672.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-776-4672.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-776-4672.]

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>	\$0
■ <u>Specialist [cost sharing]</u>	\$15
■ <u>Hospital (facility) [cost sharing]</u>	\$200
■ <u>Other [cost sharing]</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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$330

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>	\$0
■ <u>Specialist [cost sharing]</u>	\$15
■ <u>Hospital (facility) [cost sharing]</u>	\$200
■ <u>Other [cost sharing]</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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
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 plan's overall <u>deductible</u>	\$0
■ <u>Specialist [cost sharing]</u>	\$15
■ <u>Hospital (facility) [cost sharing]</u>	\$200
■ <u>Other [cost sharing]</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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$280