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 73-718 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.carefirst.com/fedhmo, and view the Glossary at www.carefirst.com/fedhmo. You can call 1-888-789-9065 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers
Are there services covered before you meet your deductible?	Yes, all In-Network services are provided without 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. "For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical and Prescription Drug Combined: $5,000 self only $10,000 self plus one $10,000 self and family Out-of-Network $8,500 self only $18,000 self plus one $18,000 self and family	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services.

What is not included in the out-of-pocket limit?	Plan premiums, health care services that plan does not cover, balance-billed over allowed amount and durable medical equipment.	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 www.carefirst.com/fedhmo or call 1-888-789-9065 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	No Charge	$80 copay per visit	Virtual Connect through CloseKnit available at $0 cost share to members 18 and over. (closeknithealth.com) Member is responsible for any amount over our allowed amount when seeing out-of-network provider in addition to the applicable copay.
	Specialist visit	$40 copay per visit	$80 copay per visit	Member is responsible for any amount over our allowed amount when seeing out-of-network provider in addition to the applicable copay.
	Retail Health Clinic	No Charge	$80 copay per visit	Member is responsible for any amount over our allowed amount

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)	
				when seeing out-of-network provider in addition to the applicable copay.
	Preventive care/screening/ immunization	No Charge	No Charge	Member is responsible for any amount over our allowed amount when seeing out-of-network provider in addition to the applicable copay.
If you have a test	Diagnostic test (x-ray, blood work)	Lab tests: Non-Hospital: No Charge Outpatient Hospital: No Charge X-rays: Non-Hospital: $40 copay per visit Outpatient Hospital: $40 copay per visit	Lab tests: Non-Hospital: No Charge Outpatient Hospital: 20% of Plan Allowance X-rays: Non-Hospital: $40 copay per visit Outpatient Hospital: 20% of Plan Allowance	HMO prior authorization is required at a hospital; nothing for tests such as blood tests, urinalysis, routine pap tests, pathology, x-rays at preferred network providers. Copay and/or coinsurance will apply at other providers.
	Imaging (CT/PET scans, MRIs)	Non-Hospital: $75 copay per visit Outpatient Hospital: $75 copay per visit	Non-Hospital: $75 copay per visit Outpatient Hospital: 20% of Plan Allowance	Nothing for x-rays, CAT scans/MRI, EEG at preferred network providers. Copay and/or coinsurance will apply at other providers.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com/fedhmo	Generic drugs	No Charge (34-day supply) No Charge (90-day supply)	Not Covered	Call CareFirst Pharmacy Member Services with questions at 1-800-241-3371.
	Preferred brand drugs	$50 copay (34-day supply) $100 copay (90-day supply)	Not Covered	Call CareFirst Pharmacy Member Services with questions at 1-800-241-3371.
	Non-preferred brand drugs	$75 copay (34-day supply) $150 copay (90-day supply)	Not Covered	Call CareFirst Pharmacy Member Services with questions at 1-800-241-3371.

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)	
	Preferred Specialty drugs	$100 copay (34-day supply) $200 copay (90-day supply)	Not Covered	Drugs must be pre-approved and preferred pharmacies must be used.
	Non-preferred Specialty drugs	$150 copay (34-day supply) $300 copay (90-day supply)	Not Covered	Drugs must be pre-approved and preferred pharmacies must be used.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital: $100 copay per visit Hospital: $150 copay per visit	Non-Hospital: $150 copay per visit Hospital: $200 copay per visit	Procedures may be subject to medical review.
	Physician/surgeon fees	Non-Hospital & Hospital PCP: No Charge Specialist: $40 copay per visit	Non-Hospital & Hospital $80 copay per visit	Procedures may be subject to medical review.
If you need immediate medical attention	Emergency room care	$200 copay per visit	Paid as In-Network	For urgent situations, please call your primary care physician or FirstHelp at 1-800-535-9700. Copay waived if admitted.

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)	
	Emergency medical transportation	$100 copay per transport	$150 copay per transport	For urgent situations, please call your primary care physician or FirstHelp at 1-800-535-9700.
	Urgent care	$50 copay per visit	$80 copay per visit	For urgent situations, please call your primary care physician or FirstHelp at 1-800-535-9700.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of Plan Allowance	30% of Plan Allowance	All non-emergency admissions must be pre-authorized.
	Physician/surgeon fees	20% of Plan Allowance	30% of Plan Allowance	Member is responsible for all changes over our allowed amount. Coverage subject to medical policy guideline.

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: No Charge Outpatient Hospital Facility: $50 copay per visit	Office Visit: $80 copay per visit Outpatient Hospital Facility: $80 copay per visit	Virtual Connect through CloseKnit available at $0 cost share to members 18 and over. (closeknithealth.com) Our in-network providers are part of Magellan Behavioral Health 1-800-245-7013.
	Inpatient services	20% of Plan Allowance	30% of Plan Allowance	Inpatient care must be authorized by calling 1-800-245-7013.
If you are pregnant	Office visits	No Charge	No Charge	No copay for routine maternity care.
	Childbirth/delivery professional services	20% of Plan Allowance	30% of Plan Allowance	Coverage subject to medical policy guidelines
	Childbirth/delivery facility services	20% of Plan Allowance	30% of Plan Allowance	Maternity admissions do not require pre-certification.
If you need help recovering or have other special health needs	Home health care	$40 copay per visit	$80 copay per visit	Service must be pre-approved
	Rehabilitation services	$40 copay per visit	$80 copay per visit	Service must be pre-approved

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)	
	Habilitation services	$40 copay per visit	$80 copay per visit	Coverage only applies to physical, speech and occupational therapy for children with specified childhood conditions. Care must be medically necessary, but visit limits do not apply.
	Skilled nursing care	20% of Plan Allowance	30% of Plan Allowance	Service must be pre-approved
	Durable medical equipment	25% of Plan Allowance per device/item	50% of Plan Allowance per device/item	Service must be medically necessary.
	Hospice services	Inpatient Care: $40 copay per admission Outpatient Care: $40 copay per visit	Inpatient Care: $80 copay per admission Outpatient Care: $80 copay per visit	Service must be pre-approved and may have limits. See on-line brochure.
If your child needs dental or eye care	Children's eye exam	$10 copay per visit at Davis Vision Providers	All charges above $33	Routine eye care for children may be covered.
	Children's glasses	Not Covered	Not Covered	Discount program available to all members. This benefit is limited by fee schedule.
	Children's dental check-up	Not Covered	Not Covered	Discount program available to all members.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental Care (Adult)
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Most coverage provided outside of the U.S. See **www.carefirst.com/fedhmo**
- Routine eye care (Adult)
- Routine foot care
- Weight loss program

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 1-888-789-9065 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 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: [insert applicable contact information from instructions].

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 1-800-318-2596
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-318-2596
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-318-2596
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-318-2596

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

Questions: Call 1-888-789-9065 or visit us at www.carefirst.com/fedhmo
If you aren't clear about any of the underlined terms used in the form, see the Glossary.
You can view the Glossary at www.carefirst.com/fedhmo or call 1-888-789-9065 to request a copy.

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** **$40**
- **Hospital (facility) Coinsurance** **20%**
- **Other Copayment** **$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	$80
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,790**

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** **$40**
- **Hospital (facility) Coinsurance** **20%**
- **Other Coinsurance** **25%**

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	$730
Coinsurance	$203
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$933**

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

- **The plan's overall deductible** **$0**
- **Specialist Copayment** **$40**
- **Hospital (facility) Copayment** **$200**
- **Other Copayment** **$40**

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	$620
Coinsurance	$73
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$693**

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