**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.healthcare.gov/sbc-glossary.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 | | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes | | 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-carebenefits/ |
| **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?** | **In-Network:**<br>$6,500 / Self Only<br>$13,000 / Self plus One and Self and Family | **Out-of-Network**<br>$10,000 / Self Only<br>$20,000 / Self plus One and 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 limits until the overall family out-of pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Plan premiums, health care services that plan does not cover, and balance-billing charges | | 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. |

| 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 | $25 copay per visit | $100 copay per visit | Virtual Connect through CloseKnit available at $0 cost share to members 18 and over. (closeknithealth.com) |
| | Specialist visit | $50 copay per visit | $100 copay per visit | None |
| | Preventive care/screening/ immunization | No Charge | No Charge | None |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab tests:<br>Non-Hospital: No Charge<br>Outpatient Hospital: No Charge<br>X-rays:<br>Non-Hospital: $40 copay per visit<br>Outpatient Hospital: $40copay per visit | Lab tests:<br>Non-Hospital: $40 copay per visit<br>Outpatient Hospital: 20% of Plan Allowance<br>X-rays:<br>Non-Hospital: $40 copay per visit<br>Outpatient Hospital: 20% of Plan Allowance | Prior authorization is required for services rendered at a hospital. |
| | Imaging (CT/PET scans, MRIs) | Non-Hospital: $75 copay per visit<br>Outpatient Hospital: $75 copay per visit | Non-Hospital: $75 copay per visit<br>Outpatient Hospital: 20% of Plan Allowance | Prior authorization is required for services rendered at a hospital. |

| 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 drugs to treat your illness or condition** More information about **prescription drug coverage** is available at https://www.carefirst.com/fedhmo/plan-information/prescription-drug-benefits.html | Generic drugs | $10 copay (34-day supply)<br>$20 copay (90-day supply) | Not Covered | Call CareFirst Pharmacy Member Services with questions at 1-800-241- 3371. |
| | Preferred brand drugs | $75 copay (34-day supply)<br>$150 copay (90-day supply | Not Covered | Call CareFirst Pharmacy Member Services with questions at 1-800-241- 3371. |
| | Preferred Specialty generic drugs | $100 copay (34-day supply)<br>$200 copay (90-day supply) | Not Covered | Drugs must be pre-approved and preferred pharmacies must be used. |
| | Preferred Specialty brand drugs | $125 copay (34-day supply)<br>$250 copay (90-day supply | Not Covered | Drugs must be pre-approved and preferred pharmacies must be used. |
| | Non-preferred Specialty drugs | $175 copay (34-day supply)<br>$350 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<br>Hospital: $150 copay per visit | Non-Hospital: $150 copay per visit<br>Hospital: $200 copay per visit | Prior authorization is required. Procedures may be subject to medical review. |
| | Physician/surgeon fees | Non-Hospital & Hospital<br>PCP: $25 copay per visit<br>Specialist: $50 copay per visit | Non-Hospital & Hospital<br>$100 copay per visit | Prior authorization is required. 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) | |
| **If you need immediate medical attention** | 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 | Coverage subject to medical policy guidelines. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit:<br>$25<br>Outpatient Hospital Facility:<br>$50 copay per visit | Office Visit<br>$100 copay per visit<br>Outpatient Hospital Facility:<br>Outpatient Hospital Facility:<br>$100 copay per visit | Virtual Connect through CloseKnit is available at $0 cost share to members 18 and over. (closeknithealth.com) |
| | Inpatient services | 20% of Plan Allowance | 30% of Plan Allowance | Prior authorization is required. |
| **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. |



For more information about limitations and exceptions, see the FEHB Plan brochure RI 73-718 at www.carefirst.com/fedhmo.

| 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** | Home health care | $50 copay per visit | $100 copay per visit | Prior authorization is required. |
| | Rehabilitation services | $50 copay per visit | $100 copay per visit | Prior authorization is required. |
| | Habilitation services | $50 copay per visit | $100 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. Prior authorization is required. |
| | Skilled nursing care | 20% of Plan Allowance | 30% of Plan Allowance | Prior authorization is required. |
| | Durable medical equipment | Inpatient Care:<br>$40 copay per admission<br>Outpatient Care:<br>$40 copay per visit | Inpatient Care:<br>$80 copay per admission<br>Outpatient Care:<br>$80 copay per visit | Service must be medically necessary. |
| | Hospice services | Inpatient Care:<br>Deductible, then $35 copay per admission<br>Outpatient Care:<br>Deductible, then $35 copay per visit | Inpatient Care:<br>Deductible, then $80 copay per admission<br>Outpatient Care:<br>Deductible, then $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. |



For more information about limitations and exceptions, see the FEHB Plan brochure RI 73-718 at www.carefirst.com/fedhmo.

## 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
- 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 888-789-9065 or visit **https://www.opm.gov/healthcare-insurance/**. 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: CareFirst BlueChoice, Inc. at 888-789-9065.

**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.***

## 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*** **$50**
- **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** **$50**
- **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 | $1,275 |
| Coinsurance | $203 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,478** |

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

- **The plan's overall deductible** **$0**
- **Specialist *Copayment*** **$50**
- **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 | $690 |
| Coinsurance | $73 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$763** |

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