



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 72-001 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.afspa.org/fsbp, and view the Glossary at www.afspa.org/fsbp. You can call 1-202-833-4910 to request a copy of either document.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| <p>What is the overall <u>deductible</u>?</p> | <p>In-<u>network</u> and outside the 50 U.S.: \$300/Self Only \$600/Self Plus One \$600/Self & Family</p> <p>In-<u>network</u>, <u>out-of-network</u> and outside the 50 U.S.: \$400/Self Only \$800/Self Plus One \$800/Self & Family</p> | <p>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 <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p> |
| <p>Are there services covered before you meet your <u>deductible</u>?</p> | <p>Yes. In-<u>network</u> and outside the 50 U.S.: preventive care; In-<u>network</u> telehealth visits; inpatient hospital; surgery; accidental injury; urgent care; and prescription drugs.</p> | <p>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/.</p> |
| <p>Are there other <u>deductibles</u> for specific services?</p> | <p>No.</p> | <p>You don't have to meet <u>deductibles</u> for specific services.</p> |
| <p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p> | <p>In-<u>network</u> & Outside 50 U.S.: \$5,000 Self Only; \$7,000 Self Plus One and Self & Family</p> <p>In-<u>network</u>, outside 50 U.S. and <u>out-of-network</u>: \$7,000 Self Only; \$9,000 Self Plus One and Self & Family</p> | <p>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.</p> |
| <p>What is not included in the <u>out-of-pocket limit</u>?</p> | <p><u>Premiums</u>, balance-billed charges, dental, penalties and health care this <u>plan</u> doesn't cover.</p> | <p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p> |

| Important Questions | Answers | Why This Matters: |
|--|---|---|
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.afspa.org/fsbp or call 1-202-833-4910 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> . |



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 |
|---|--|--|--|---|
| | | <u>Network</u> or <u>Provider</u> outside the 50 U.S. (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most, plus you may be <u>balance billed</u>) | |
| If you visit a health care <u>provider's office</u> or clinic | Primary care visit to treat an injury or illness | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Deductible</u> applies |
| | <u>Specialist</u> visit | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Deductible</u> applies |
| | <u>Preventive care/screening/immunization</u> | No charge | 30% <u>coinsurance</u> | <u>Deductible</u> applies for <u>out-of-network providers</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) | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Deductible</u> applies |
| | Imaging (CT/PET scans, MRIs) | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Deductible</u> applies. Prior approval required in U.S. |
| | Quest Diagnostic Lab | No charge (U.S. only) | Not available | U.S. Only |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---------------------------|---|--|---|
| | | <u>Network or Provider</u> outside the 50 U.S. (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most, plus you may be <u>balance billed</u>) | |
| <p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.afspa.org/fsbp.</p> | Generic drugs | Retail in U.S.: \$10 copay; outside U.S.: 10% <u>coinsurance</u> Smart90 retail in U.S. & home delivery: \$15 copay | 100% of cost | Retail: 30-day maximum supply; Smart90 retail & home delivery: 90-day maximum supply. 1 year if posted or traveling outside U.S. (mailing restrictions may apply). Non- <u>specialty</u> maintenance medication must be filled through Smart90 retail & home delivery. |
| | Preferred brand drugs | Retail in U.S.: 25% <u>coinsurance</u> (\$30 minimum); outside U.S.: 10% <u>coinsurance</u> Smart90 retail in U.S. & home delivery: \$60 copay | 100% of cost | Retail: 30-day maximum supply; Smart90 retail & home delivery: 90-day maximum supply. One year if posted or traveling outside U.S. (mailing restrictions may apply). Non- <u>specialty</u> maintenance medication must be filled through Smart90 retail & home delivery. |
| | Non-preferred brand drugs | Retail in U.S.: 35% <u>coinsurance</u> (\$60 minimum); outside U.S.: 10% <u>coinsurance</u> Smart90 retail in U.S. & home delivery: 35% <u>coinsurance</u> (\$80 minimum; \$500 maximum) | 100% of cost | Retail: 30-day maximum supply; Smart90 retail & home delivery: 90-day maximum supply. One year if posted or traveling outside U.S. (mailing restrictions may apply). Non- <u>specialty</u> maintenance medication must be filled through Smart90 retail & home delivery. |
| | <u>Specialty drugs</u> | Retail in U.S.: Generic & Preferred Brand 25% <u>coinsurance</u> ; Non-preferred brand 35%; outside U.S.: 10% <u>coinsurance</u> Home delivery: Generic 25% <u>coinsurance</u> (\$150 maximum); Preferred brand 25% <u>coinsurance</u> (\$200 max); Non-preferred brand 35% <u>coinsurance</u> (\$300 maximum) | 100% of cost | Retail: 30-day maximum supply, no coverage for chronic RX (home delivery only); Home Delivery: 90-day maximum supply. One year if posted or traveling outside U.S. (mailing restrictions may apply, i.e. <u>specialty</u> , temperature controlled items). Prior authorization required. Non- <u>specialty</u> maintenance medication must be filled through Smart90 retail & home delivery; <u>specialty</u> home delivery through Accredo only. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|---|
| | | <u>Network</u> or <u>Provider</u> outside the 50 U.S. (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most, plus you may be <u>balance billed</u>) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Deductible</u> applies. |
| | Physician/surgeon fees | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | |
| If you need immediate medical attention | <u>Emergency room care</u> | Accident: No charge; Medical emergency: 10% <u>coinsurance</u> | Accident: Charges over <u>plan</u> allowance; Medical emergency: 10% plus amount over <u>Plan</u> allowance | <u>Deductible</u> applies for medical emergency. |
| | <u>Emergency medical transportation</u> | 10% <u>coinsurance</u> | 10% <u>coinsurance</u> | |
| | <u>Urgent care</u> | Accident: No charge; Medical emergency: \$35 copay | Accident: No charge; Medical emergency: \$35 copay plus amount over <u>Plan</u> allowance | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | \$200 copay per admission plus 20% <u>coinsurance</u> | Precertification required in U.S. (if not precertified \$500 penalty applies). <u>Deductible</u> applies for medical services, not for surgical services. |
| | Physician/surgeon fees | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Deductible</u> applies; prior approval required for certain services rendered in U.S.; prior approval required for Applied Behavioral Analysis services rendered in and outside the U.S. |
| | Inpatient services | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|--|
| | | <u>Network or Provider</u> outside the U.S. (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most, plus you may be <u>balance billed</u>) | |
| If you are pregnant | Office visits | No charge | 30% <u>coinsurance</u> | |
| | Childbirth/delivery professional services | No charge | 30% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | No charge | \$200 copay per admission plus 20% <u>coinsurance</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | 90 visit limit per year |
| | <u>Rehabilitation services</u> | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | 125 visit limit (combined) per year; <u>deductible</u> applies. |
| | <u>Habilitation services</u> | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | 125 visit limit (combined) per year; <u>deductible</u> applies. |
| | <u>Skilled nursing care</u> | No charge | \$200 copay per admission plus 20% <u>coinsurance</u> | Precertification required in the U.S. (if not precertified \$500 penalty applies); 90-days per calendar year maximum. |
| | <u>Durable medical equipment</u> | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Deductible</u> applies. \$1,000 limit per augmentative and alternative communication device per calendar year |
| | <u>Hospice services</u> | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | |
| If your child needs dental or eye care | Children's eye exam | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | Routine eye exams not covered; <u>deductible</u> applies. |
| | Children's glasses | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | Cover one pair of eyeglasses with standard frames and must be related to accidental injury, intraocular surgery, keratoconus or glaucoma; <u>deductible</u> applies. |
| | Children's dental check-up | No charge for two preventive care exams per person per year | No charge for two preventive care exams per person per year | You pay all charges exceeding <u>plan's</u> scheduled allowance for the service. |

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
- Custodial care
- Routine eye care (Adult and Children)
- Routine foot care
- Long-term care

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

- Acupuncture up to \$60 per visit and up to 40 visits per calendar year
- Bariatric surgery (must be age 18 & older and meet certain criteria)
- Chiropractic care up to \$60 per visit and up to 40 visits per calendar year
- Coverage provided outside the United States. See www.afspa.org/fsbp
- Dental care (Adult) subject to fee schedule
- Hearing aids (once every three calendar years up to \$4,000 per person)
- Infertility treatment does not include assisted reproductive technology (ART) procedures
- Private-duty nursing if prescribed by a physician (included in home health care; subject to 90 visit limit per year)
- Weight loss programs (as part of Preventive care)

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 1-202-833-4910 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 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 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 plan's FEHB brochure. If you need assistance, you can contact: customer service at 1-202-833-4910.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-202-833-4910.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-202-833-4910.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-202-833-4910.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-202-833-4910.]

————— *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 \$300
- Specialist [coinsurance] 10%
- Hospital (facility) [no charge] 0%
- Other [cost sharing] 10%

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:

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

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$300
- Specialist [coinsurance] 10%
- Hospital (facility) [No charge] 0%
- Other [cost sharing] 10%

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 | \$7,400 |
|--------------------|---------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$300 |
| Copayments | \$700 |
| Coinsurance | \$1,000 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,020 |

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

- The plan's overall deductible \$300
- Specialist [coinsurance] 10%
- Hospital (facility) [no charge] 0%
- Other [cost sharing] 10%

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 | \$1,900 |
|--------------------|---------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$300 |
| Copayments | \$0 |
| Coinsurance | \$100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$400 |