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 PSHB Plan brochure (RI 71-025) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the PSHB 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 PSHB Plan brochure at fepblue.org/brochure, and view the Glossary at www.dol.gov/ebsa/healthreform. You can call 1-800-411-2583 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 500/Self Only $ 1,000/Self Plus One $ 1,000/Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. 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. Preventive care, 10 office visits, telehealth, urgent care, manipulation treatments, and acupuncture are covered before you meet your 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?	$ 9,000/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. 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?	Premiums, balance-billing charges, health care this plan doesn't cover, and penalties for failure to obtain preauthorization for services.	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 provider.fepblue.org or call your local BCBS company 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	$10/visit. Deductible does not apply.	Not covered	10 visits/calendar year for primary care, specialists, and other healthcare professionals combined. Deductible and coinsurance applies starting on the 11th visit. You pay nothing when you receive care in connection with, and within 72 hours after, an accidental injury.
	Specialist visit	$10/visit. Deductible does not apply.	Not covered	10 visits/calendar year for primary care, specialists, and other healthcare professionals combined. Deductible and coinsurance applies starting on the 11th visit.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	There is no charge for the first 10 laboratory tests performed in each of these different laboratory test categories (Basic metabolic panels; Cholesterol screenings; Complete blood counts; Fasting lipoprotein profiles; General health panels; Urinalysis) and 10

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)	
				Venipunctures when not associated with preventive, maternity or accidental injury care.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Prior approval is required. There is a $100 penalty if prior approval is not obtained.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at fepblue.org/formulary	Tier 1 (Preferred generic drugs)	$5/prescription (30-day supply). Deductible does not apply.	Not covered	$15/prescription for a 31 to 90-day supply. Non-preferred generic drugs are excluded.
	Tier 2 (Preferred brand-name drugs, Preferred generic specialty drugs and Preferred brand-name specialty drugs)	40% coinsurance. Deductible does not apply.	Not covered	$350 maximum/prescription for a 30-day supply. $1,050 maximum/prescription up to a 90-day supply. Non-preferred brand name drugs and Non-preferred specialty drugs are excluded.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	Prior approval is required for certain surgical services. There is a $100 penalty if prior approval is not obtained.
	Physician/surgeon fees	30% coinsurance	Not covered	Prior approval is required for certain surgical services. There is a $100 penalty if prior approval is not obtained.
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	You pay nothing when you receive care for your accidental injury within 72 hours.
	Emergency medical transportation	30% coinsurance	30% coinsurance	You pay nothing when you receive care for your accidental injury within 72 hours.
	Urgent care	$25/visit. Deductible does not apply.	Not covered	You pay nothing when you receive care for your accidental injury within 72 hours. You pay $25/visit for care in connection with medical emergency services performed at an out-of-network urgent care facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Precertification is required. We will reduce benefits for the inpatient hospital stay by $500 if no one contacts us for precertification.

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)	
	Physician/surgeon fees	30% coinsurance	Not covered	Prior approval is required for certain surgical services. There is a $100 penalty if prior approval is not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	Not covered	Prior approval is required for outpatient residential treatment services.
	Inpatient services	30% coinsurance	Not covered	Precertification is required for inpatient hospital stays. We will reduce benefits for the inpatient hospital stay by $500 if no one contacts us for precertification.
If you are pregnant	Office visits	No charge. Deductible does not apply.	Not covered	Prior notification is requested. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge. Deductible does not apply.	Not covered	Prior notification is requested.
	Childbirth/delivery facility services	$1,500 copayment. Deductible does not apply.	Not covered	Prior notification is requested.
If you need help recovering or have other special health needs	Home health care	$25/visit. Deductible does not apply.	Not covered	10 visits/calendar year
	Rehabilitation services	$25/visit. Deductible does not apply.	Not covered	25 visits/calendar year. Includes physical, occupational and speech therapies.
	Habilitation services	$25/visit. Deductible does not apply.	Not covered	25 visits/calendar year. Coverage is limited to physical, occupational and speech therapies.
	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	30% coinsurance	Not covered	Some services require prior authorization. There is a $100 penalty if prior approval is not obtained.
	Hospice services	Traditional Home Hospice Care and Continuous Home	Not covered	Prior approval is required for all hospice services. There is a $100 penalty if prior approval is not obtained.

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)	
		Hospice Care: No charge Inpatient Hospice Care: 30% coinsurance		Inpatient Hospice Care: Benefits are provided for up to 30 consecutive days in a facility licensed as an inpatient hospice facility.
If your child needs dental or eye care	Children's eye exam	30% coinsurance	Not covered	Coverage is limited to exams related to treatment of a specific medical condition.
	Children's glasses	30% coinsurance	Not covered	Coverage is limited to one pair of glasses per incident prescribed for certain medical conditions.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

- Assisted Reproductive Technologies (ART)
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

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

- Acupuncture (10 visits combined with chiropractic care/calendar year)
- Bariatric surgery
- Chiropractic care (10 visits combined with acupuncture/calendar year)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine foot care if you are under active treatment for a metabolic or peripheral vascular disease

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the PSHB Plan brochure, contact your HR office/retirement system, contact your plan at [contact number] 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-PSHB 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 PSHB Plan brochure. If you need assistance, you can contact your local BCBS company at the customer service number on the back of your member ID card.

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 servicio de atención al cliente al número que aparece en su tarjeta de identificación.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.]
[Chinese (中文): 請撥打您 ID 卡上的客服號碼以尋求中文協助。.]
[Navajo (Dine): Diné k'ehjí yá'áti' bee shíká'adoowoł nohsingo naaltsoos nihaa halne'go nidaahtinígíí bine'déé' Customer Service bibéésh bee hane'é biká'ígíí bich'į' dahodoołnih.]

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	$500
Specialist *[cost sharing]*	$10
Hospital (facility) *[cost sharing]*	$1,500
Other *[cost sharing]*	30%

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	$1500
Coinsurance	$50
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1610**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$10
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

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	$500
Copayments	$20
Coinsurance	$ 1700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$ 2240**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$10
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

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	$500
Copayments	$100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1000**

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