




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> (including Guam) and outside the 50 U.S.: \$300/Self Only \$600/Self Plus One \$600/Self & Family</p> <p>Out-of-<u>network</u> (including Guam) 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-network and outside the 50 U.S.: preventive care; 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. See a list of covered <u>preventive services</u> at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-brecommendations.</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. (including Guam): \$5,000 Self Only; \$7,000 Self Plus One and Self & Family</p> <p>Out-of-<u>network</u> (including Guam): \$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 plan, 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>



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 provider <u>network</u> . You will pay less if you use a provider 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 (balance billing). 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.	This <u>plan</u> does not require a referral to see a <u>specialist</u> for covered services.

 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 or Provider outside the 50 U.S. (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 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</u> providers. 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.
	<u>Professional non-emergency services</u>	CVS Minute Clinic: No charge Walk-in Clinic (non-CVS Minute Clinic): \$10 <u>copayment</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies for <u>out-of-network</u> providers.
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
	Labs performed by Quest Diagnostics or LabCorp	No charge (U.S. only)	Not available	Available in the U.S. Only

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network or Provider outside the 50 U.S. (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 www.afspa.org/fsbp	Generic drugs	Retail in U.S.: \$10 <u>copayment</u> ; outside U.S.: 10% <u>coinsurance</u> Smart90 retail in U.S. & home delivery: \$15 <u>copayment</u>	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; \$100 maximum); outside U.S.: 10% <u>coinsurance</u> Smart90 retail in U.S. & home delivery: \$60 <u>copayment</u>	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; \$200 maximum); 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 25% <u>coinsurance</u> (\$150 maximum); Preferred Brand 25% <u>coinsurance</u> (\$200 maximum); Non-preferred brand 35% <u>coinsurance</u> (\$300 maximum); outside U.S.: 10% <u>coinsurance</u> Home delivery: Generic 25% <u>coinsurance</u> (\$150 maximum); Preferred brand 25% <u>coinsurance</u> (\$200 maximum); Nonpreferred 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
		Network or Provider outside the 50 U.S. (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% coinsurance	<u>Deductible</u> applies
	Physician/surgeon fees	10% <u>coinsurance</u>	30% coinsurance	<u>Deductible</u> applies for medical services, not for surgical services.
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 <u>copayment</u>	Accident: Charges over <u>Plan</u> allowance; Medical emergency: \$35 <u>copayment</u> plus amount over <u>Plan</u> allowance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$200 <u>copayment</u> per admission plus 20% <u>coinsurance</u>	Precertification required in U.S. (if not precertified \$500 penalty applies).
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies for medical services, not surgical services.
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>	<u>Deductible</u> applies
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network or Provider outside the 50 U.S. (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge	\$200 <u>copayment</u> 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 calendar year
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	125 visit limit (combined) per calendar year; <u>deductible</u> applies.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies.
	<u>Skilled nursing care</u>	No charge	\$200 <u>copayment</u> 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 FEHB Plan 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 FEHB Plan brochure.)

- Acupuncture up to \$75 per visit and up to 50 visits per calendar year
- Bariatric surgery (must meet certain criteria)
- Chiropractic up to \$75 per visit and up to 50 visits per calendar year
- Coverage provided outside the United States. See www.afspa.org/fsbp
- Dental care (Adult) subject to fee schedule
- Doula support (up to \$1,200 maximum per calendar year)
- Gender affirming surgery (must meet certain criteria)
- Hearing aids (once every three calendar years up to \$4,000 per person)
- Infertility services (must meet certain criteria)
- Massage therapy up to \$75 per visit and up to 50 visits per calendar year
- Private-duty nursing if prescribed by a physician (included in home health care; subject to 90 visit limit per calendar 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/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 Customer Service at 1-202-833-4910.

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 1-202-833-4910.]

[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, kwijijigo 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 <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	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
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In this example, Peg would pay:

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

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$80
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,200

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$410

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