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 71-020) 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.opm.gov/healthcare-insurance/insurance-glossary/. 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?	$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. There's no deductible for covered services.	This plan does not have a deductible.
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?	$8,500/Self Only $17,000/Self Plus One $17,000/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	$35/visit for adults; $20/visit for kids up to age 18	Not covered	You pay 35% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care. You pay nothing when you receive care in connection with an accidental injury.
	Specialist visit	$50/visit	Not covered	You pay 35% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care.
	Preventive care/screening/ immunization	No charge	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)	You pay 15% coinsurance for blood work; $40 copayment for X-rays	Not covered	You pay 35% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care.
	Imaging (CT/PET scans, MRIs)	$100 (when billed by professionals); $250 (billed by facilities)	Not covered	You pay 35% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care.
If you need drugs to treat your illness or condition More information about prescription drug	Tier 1 (Generic drugs)	$15/prescription (30-day supply)	Not covered	$40/prescription for a 31- to 90-day supply for additional copayments
	Tier 2 (Preferred brand drugs)	35% coinsurance / $250 maximum (30-day supply)	Not covered	$500 maximum for a 31- to 90-day supply for additional copayments
	Tier 3 (Non-preferred brand drugs)	60% coinsurance / $550 maximum (30-day supply)	Not covered	$1,650 maximum for a 31-to 90-day supply.

coverage is available at fepblue.org/formulary	Tier 4 (Preferred Specialty drugs)	Retail: 35% coinsurance / $450 maximum (30-day supply) Specialty pharmacy: $35% coinsurance /	Not covered	Retail: One fill limit
Common Medical Event	**Services You May Need**	**What You Will Pay** **Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most, plus you may be balance billed)**	**Limitations, Exceptions, & Other Important Information**
		$450 maximum (30-day supply)		Prior approval is required for certain prescription drugs.
	Tier 5 (Non-preferred specialty drugs)	Retail: 40% coinsurance / $550 maximum (30-day supply) Specialty pharmacy: 40% coinsurance / $550 maximum (30-day supply	Not covered	Retail: One fill limit Prior approval is required for certain prescription drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250/day per facility	Not covered	You pay 35% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care.
	Physician/surgeon fees	$150/performing surgeon (office setting); $200/performing surgeon (other settings)	Not covered	You pay 35% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care. Prior approval is required for certain surgical services.
If you need immediate medical attention	Emergency room care	$500 per day per facility	$500 per day per facility	None
	Emergency medical transportation	$100/day	$100/day	Air or sea ambulance: $150/day. Prior approval is required for non-emergent air ambulance transport.

	Urgent care	$50/visit	Not covered	You pay $50/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)	$500/day up to maximum of $3,500/admission	Not covered	Precertification is required. We will reduce benefits for the inpatient hospital stay by $500 if no one contacts us for precertification.
	Physician/surgeon fees	$200/performing surgeon	Not covered	Prior approval is required for certain surgical services. You pay 35% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care.
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)**	
				You pay 35% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care.
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$35 copay/office visit for adults, $20 copay/office visit for kids up to age 18, and no charge for outpatient services	Not covered	You pay 35% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care.
	Inpatient services	No charge for professional services/ $500/day up to maximum of $3,500/admission for facility care	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.
	Office visits	No charge	Not covered	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	Not covered	None

If you are pregnant	Childbirth/Delivery Facility Services	No charge for delivery at a Blue Distinction Center®, $500/admission for other facilities	Not covered	None
If you need help recovering or have other special health needs	Home health care	$35/visit	Not covered	25 visit limit/calendar year.
	Rehabilitation services	$35/visit (primary care); $50/visit (specialist)	Not covered	50 visit limit/calendar year. Includes physical, occupational and speech therapies. You pay 35% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care.
	Habilitation services	$35/visit (primary care); $50/visit (specialist)	Not covered	50 visit limit/calendar year. Coverage is limited to physical, occupational and speech therapies. You pay 35% coinsurance for agents, drugs, and/or supplies administered or obtained in connection with your care.
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)**	
	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	35% coinsurance	Not covered	None
	Hospice services	No charge	Not covered	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	$35/visit (primary care); $50/visit (specialist)	Not covered	Coverage limited to exams related to treatment of a specific medical condition.
	Children's glasses	35% coinsurance	Not covered	Coverage limited to one pair of glasses per incident prescribed for certain medical conditions.
	Children's dental check-up	$35/evaluation	Not covered	Coverage limited to two visits/calendar year.

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
- Long-term care
- Private duty nursing
- Routine eye care
- 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 (12 visits per calendar year) • Bariatric surgery • Chiropractic care (20 visits per calendar year)	• Dental care • Hearing aids • Infertility treatment	• Non-emergency care when traveling outside the U.S. • Routine foot care if you are under active treatment for 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 the number on the back of your ID card or visit https://health-benefits.opm.gov/pshb. 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	$0
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing]*	35%

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	$585
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$645**

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 *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing]*	35%

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	$1,840
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,060**

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing]*	35%

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	$845
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,035**

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