




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 ([insert brochure number]) 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.rcbphealth.com and view the Glossary at www.rcbphealth.com. You can call 1-800-638-8432 to request a copy of either document.

Important Questions	Answers	Why This Matters:
<p>What is the overall <u>deductible</u>?</p>	<p><u>In-network</u>: \$350/Self Only \$700/Self Plus One \$700/Self and Family <u>In-network and Out-of-network</u>: \$800/Self Only \$1,600/Self Plus One \$1,600/Self and 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. <u>In-network preventive care</u>; <u>In-network office visits</u>, <u>In-network inpatient hospital</u>; <u>In-network surgery</u>; <u>Emergency services</u>; and 90-day supply of <u>prescription drugs</u>.</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-and-b-recommendations.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes. \$200 per person for retail prescriptions. Retail <u>deductible</u> is waived when Medicare Part A and B are primary. \$50 per person for dental coverage for all services except for <u>preventive services</u>.</p>	<p>You must pay all the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p><u>In-network providers</u>: \$5,000/Self Only \$10,000/Self Plus One or Self and Family <u>Out-of-network providers</u>: \$7,000/Self Only \$14,000/Self Plus One or Self and 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 must meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>



What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , balance-billed charges, penalties, expenses covered by <u>specialty drug copayment</u> assistance cards, and non-covered services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.rcbphealth.com or call 1-800-638-8432 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 plan's <u>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</u> charge 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.	This <u>plan</u> does not require a <u>referral</u> 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 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 <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$20 <u>copayment</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies to <u>out-of-network providers</u> . Professional services of a physician outside the office setting are 15% <u>coinsurance</u> subject to <u>deductible</u> for <u>network services</u> .
	<u>Specialist</u> visit	\$35 <u>copayment</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies to <u>out-of-network providers</u> . Professional services of a physician outside the office setting are 15% <u>coinsurance</u> subject to <u>deductible</u> for <u>network services</u> .
	<u>Preventive care/screening/Immunization</u>	No charge	30% <u>coinsurance</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.
	Professional non-emergency services	CVS Minute Clinic: No charge Other Walk-in Clinic: \$10 copayment	30% <u>coinsurance</u>	

If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies to In and out-of-network.
	Lab Savings Program	No charge	Not available	For covered lab tests performed by Quest Diagnostics or LabCorp.
	Imaging (CT/PET scans, MRIs)	5% <u>coinsurance</u> at a stand-alone <u>network</u> imaging center or clinic; 15% <u>coinsurance</u> at other providers	30% <u>coinsurance</u>	<u>Deductible</u> applies to In and out-of-network. Prior approval is required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.rcbhealth.com	Generic drugs	\$200 per person retail <u>deductible</u> then 30% <u>coinsurance</u> ; <u>maximum \$7.50</u> Mail: \$10 <u>copayment</u>	\$200 per person retail <u>deductible</u> then 30% <u>coinsurance</u> Mail not covered	Max 34-day (retail)/90-day (mail). After 3 retail fills, maintenance drugs are only covered at mail or retail CVS pharmacy.
	Preferred brand drugs	\$200 per person retail <u>deductible</u> then 30%; <u>maximum \$200</u> Mail: \$50 <u>copayment</u>	\$200 per person retail <u>deductible</u> then 30% Mail not covered	Max 34-day (retail)/90-day (mail). Mail: \$40 <u>copayment</u> for <u>network</u> pharmacy when Medicare Part B is primary. After 3 retail fills, maintenance drugs are only covered at CVS Caremark mail service pharmacy or at a retail CVS pharmacy.
	Non-preferred brand drugs	\$200 per person retail <u>deductible</u> then 30% <u>coinsurance</u> ; <u>maximum \$200</u> Mail: \$80 <u>copayment</u>	\$200 per person retail <u>deductible</u> then 30% <u>coinsurance</u> Mail not covered	Max 34-day (retail)/90-day (mail). Mail: \$70 <u>copayment</u> for <u>network</u> pharmacy when Medicare Part B is primary. After 3 retail fills, maintenance drugs are only covered at CVS Caremark mail service pharmacy or at a retail CVS pharmacy.

If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.rcbphhealth.com	<u>Specialty Generic drugs</u>	Specialty: \$70 copayment for a 30-day supply; \$100 copayment for a 90-day supply	Mail not covered	<u>Specialty drugs</u> must be obtained through CVS Caremark Specialty Pharmacy. <u>Preauthorization</u> is required.
	<u>Specialty Preferred drugs</u>	Specialty: \$90 copayment for a 30-day supply; \$125 copayment for a 90-day supply	Mail not covered	<u>Specialty drugs</u> must be obtained through CVS Caremark Specialty Pharmacy. <u>Preauthorization</u> is required.
	Specialty Non-Preferred drugs	Specialty: \$120 copayment for a 30-day supply; \$250 copayment for a 90-day supply	Mail not covered	Specialty drugs must be obtained through CVS Caremark Specialty Pharmacy. <u>Preauthorization</u> is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies In and out-of-network.
	Physician/surgeon fees	15% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies to <u>out-of-network providers</u> .
If you need immediate medical attention	<u>Emergency room care</u>	Accident: No charge; Medical emergency: \$200 <u>copayment</u>	Accident: Difference between <u>Plan</u> allowance and billed amount. <i>Medical emergency:</i> \$200 <u>copayment</u>	
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	
	<u>Urgent care</u>	\$35 <u>copayment</u> per visit	30% <u>coinsurance</u>	<u>Deductible</u> applies to <u>out-of-network providers</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 <u>copayment</u> per admission	\$400 <u>copayment</u> per admission and 30% <u>coinsurance</u>	Precertification is required.
	Physician/surgeon fees	15% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies to <u>out-of-network</u> physician and surgeon.

If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copayment</u> per primary care visit; 15% <u>coinsurance</u> for all other services	30% <u>coinsurance</u>	<u>Deductible</u> applies to out-of-network office visits and outpatient services. Certain services require prior approval.
	Inpatient services	\$200 <u>copayment</u> per admission	\$400 <u>copayment</u> per admission and 30% <u>coinsurance</u>	Precertification is required.
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u>	<u>Deductible</u> applies to out-of-network.
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	<u>Deductible</u> applies to out-of-network.
	Childbirth/delivery facility services	No charge	\$400 <u>copayment</u> per admission and 30% <u>coinsurance</u>	<u>Deductible</u> applies to out-of-network.
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	Limit 90 visits per year.
	<u>Rehabilitation services</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 90 visits per year combined. <u>Deductible</u> applies In and <u>out-of-network</u> .
	<u>Habilitation services</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies In and <u>out-of-network</u> .
	<u>Skilled nursing care</u>	\$200 <u>copayment</u> per admission	\$400 <u>copayment</u> per admission and 30% <u>coinsurance</u>	Precertification is required. Limited to 60 days per calendar year.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies.
	<u>Hospice services</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	
If your child needs dental or eye care	Children's eye exam	All charges over \$45	All charges over \$45	Benefit limited to \$45 for routine eye exam.
	Children's glasses	15% <u>coinsurance</u>	30% <u>coinsurance</u>	Cover one pair of glasses with standard frames and must be related to an accidental injury or intraocular surgery. <u>Deductible</u> applies.
	Children's dental check-up	No charge for two <u>preventive care</u> exams per person per year	No charge for two <u>preventive care</u> exams per person per year	Member pays all charges exceeding Plan's 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
- Long-term care
- Private-duty nursing
- Routine foot care

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
- Massage therapy
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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 1-800-638-8432 or visit <http://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 1-800-638-8432.

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 1-800-638-8432.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-638-8432.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-638-8432.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-638-8432.]

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 <u>deductible</u>	\$350
■ <u>Specialist [cost sharing]</u>	\$35
■ <u>Hospital (facility) [cost sharing]</u>	\$0
■ <u>Other [cost sharing]</u>	15%

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>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$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 <u>deductible</u>	\$350
■ <u>Specialist [cost sharing]</u>	\$35
■ <u>Hospital (facility) [cost sharing]</u>	\$0
■ <u>Other [cost sharing]</u>	15%

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,720

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$350
■ <u>Specialist [cost sharing]</u>	\$35
■ <u>Hospital (facility) [cost sharing]</u>	\$0
■ <u>Other [cost sharing]</u>	15%

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$350
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$750