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 73-574 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.blueshieldca.com/federal/sbc, and view the Glossary at https://www.blueshieldca.com/federal/sbc. You can call 1-800-880-8086 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	We do not have a deductible.	The Plan does not have a calendar year deductible. See common medical
Are there other deductibles for specific services?	N/A	You don't have to meet deductibles for any services.
What is the out-of-pocket limit for this plan?	$ 5,000 /Self Only $ 10,000 /Self Plus One $ 10,000 /Self and Family	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Infertility 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?	There are no out-of-network benefits with this plan.	This plan uses a provider network. 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?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. Also, members may self-refer using the Access+ Self-Refer feature.

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	$30	Not Covered	None
	Specialist visit	$40	Not Covered	Members may self-refer using the Access+ Self-Refer feature.
	Preventive care/screening/ immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$200	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.blueshieldca.com/pharmacy	Tier 1	$10 per Tier 1 prescription (retail 30-day supply) $20 per Tier 1 prescription (mail order 90-day supply)	Not Covered	A retail plan pharmacy may dispense up to a 30-day supply for the appropriate copayment. Some prescriptions have specific limits on how much of the medication you can get with each prescription or refill. Specialty drugs are not available through the Mail Service Prescription Drug Program.
	Tier 2	$50 per Tier 2 prescription (retail 30-day supply) $100 per Tier 2 prescription (mail order 90 day supply)	Not Covered	None
	Tier 3	50% per Tier 3 prescription (retail 30-day supply), $50 minimum/$200 maximum 50% per Tier 3 prescription (90-day supply), $100 minimum/$400 maximum	Not Covered	None

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)	
	Tier 4	30% per Tier 4 retail Plan pharmacy prescription, up to $250 maximum (excluding specialty drugs) 30% per Tier 4 mail service prescription, up to $300 maximum (excluding specialty drugs)	Not Covered	None
	Network Specialty Pharmacy (up to 30-day supply)	30% per Tier 4 prescription, up to $250 maximum (includes home self-injectable and specialty drugs) Value-Based Tier Drugs	Not Covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room care	$200	Not Covered	If the emergency results in admission to a hospital, the copayment is waived. Elective care/non-emergency care not covered out of service area.
	Emergency medical transportation	No Charge	Not Covered	None
	Urgent care	$30	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$750	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 per visit	Not Covered	None
	Inpatient services	$250 per day up to 3 days	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	None

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)	
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	None
If you need help recovering or have other special health needs	Home health care	$5 for a registered caregiver $25 for a physician visit	Not Covered	None
	Rehabilitation services	$20 per visit	Not Covered	None
	Habilitation services	$20 per visit	Not Covered	None
	Skilled nursing care	No Charge	Not Covered	We provide benefits up to 100 days each calendar year when full time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate. Member pays all charges after 100 days.
	Durable medical equipment	50% of plan allowance	Not Covered	None
	Hospice services	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- Artificial Organ Transplants
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Infertility Services after Voluntary Sterilization
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Out-of-Network Care
- Private-duty nursing,
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)	
• Chiropractic Care	• Bariatric Surgery
• Hearing Aids	• Infertility Services

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 [contact number] 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 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 our Customer Service Department by calling (800) 880-8086.

Does this plan provide Minimum Essential Coverage? [Yes]

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 (800) 880-8086.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 880-8086.
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** (800) 880-8086.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 880-8086.

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 *[copayment]*	$0
Hospital (facility) *[copayment]*	$750
Other *[copayments]*	$93

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	$843
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$843

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 *[copayment]*	$40
Hospital (facility) *[copayment]*	$0
Other *[copayments]*	$1355

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:

Cost Sharing	
Deductibles	$0
Copayments	$1355
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1365

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

The plan's overall deductible	$0
Specialist *[copayment]*	$0
Hospital (facility) *[copayment]*	$200
Other *[copayments]*	$289

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:

Cost Sharing	
Deductibles	$0
Copayments	$489
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$489

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