This is only a summary. Please read the FEHB Plan brochure (73-874]) 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. You can get the FEHB Plan brochure at www.calvos.com or by calling 671-477-9808.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**No deductible** for in-network services	You must pay all the costs up to the **deductible** amount before this plan begins to pay for certain covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible** and for which services are subject to the **deductible**.
Are there other deductibles for specific services?	Out of Network $ 500/Self Only $ 1,000/Self Plus One $ 1,500/Self and Family	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	$ 2,000/Self Only $ 4,000/Self Plus One ($2,000 per covered individual) $ 6,000/Self and Family ($2,000 per covered individual)	The **out-of-pocket limit,** or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses. The "per covered individual" amount is the most that any one member would have to pay, regardless of whether the individual is enrolled in Self Plus One, or Self and Family.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-

		network **provider** for some services. [We use the terms **preferred** or participating for **providers** in our **network**.] See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes	
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See this plan's FEHB brochure for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay / visit	30% coinsurance	Preferred Provider copay is $5 / visit
	Specialist visit	$40 copay / visit	30% coinsurance	----------none----------
	Other practitioner office visit	Charges above $25 / visit	All charges	20 visits (chiropractor/acupuncture) per benefit year.
	Preventive care/screening/immunization	$0	30% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay / visit	30% coinsurance	
	Imaging (CT/PET scans, MRIs)	$40 copay / visit	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].	Generic drugs	$10	All charges	
	Preferred brand drugs	$25	All charges	
	Non-preferred brand drugs	50% of AWP	All charges	
	Specialty drugs	$100	All charges	

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100	30% coinsurance	----------none----------
	Physician/surgeon fees	$0	30% coinsurance	Included in facility fee
If you need immediate medical attention	Emergency room services	$100	$100	Plus charges above eligible charges
	Emergency medical transportation	$0	30% coinsurance	----------none----------
	Urgent care	$15 copay	30% coinsurance	$50 copay/visit in hospital setting in service area
If you have a hospital stay	Facility fee (e.g., hospital room)	$200	30% coinsurance	----------none----------
	Physician/surgeon fee	$0	30% coinsurance	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay / specialist visit; $100 copay per outpatient facility visit	30% coinsurance	----------none----------
	Mental/Behavioral health inpatient services	$200 copay for facility fee/ No copay for physician fee	30% coinsurance	----------none----------
	Substance misuse disorder outpatient services	$40 copay / specialist visit; $100 copay per outpatient facility visit	30% coinsurance	----------none----------
	Substance misuse disorder inpatient services	$200 copay for facility fee/ No copay for physician fee	30% coinsurance	----------none----------
If you are pregnant	Prenatal and postnatal care	$0	30% coinsurance	----------none----------
	Delivery and all inpatient services	$100 copay for birthing center; $200 copay for hospital	All charges.	You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a caesarean delivery.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$0	30% coinsurance	
	Rehabilitation services	$40 copay / specialist visit	30% coinsurance	Physical, occupational, and speech therapy; cardiac rehabilitation
	Habilitation services	$40 copay / specialist visit	30% coinsurance	Autism-related services
	Skilled nursing care	$0	30% coinsurance	Up to 100 days per calendar year
	Durable medical equipment	20% coinsurance	All charges.	Limited to manual hospital beds, standard manual wheelchairs, crutches, walkers, blood glucose monitors, CPAP, BIPAP
	Hospice service	$0	All charges.	----------none----------
If your child needs dental or eye care	Eye exam	$15 copay / PCP visit; $40 copay /specialist visit	30% coinsurance	----------none----------
	Glasses	All charges above $100	All charges above $100	Maximum $100 benefit per benefit year
	Dental check-up	$0	All charges.	Preventive services only

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check this plan's FEHB brochure for other excluded services.)

- Cosmetic surgery
- Services listed in Section 6 of our FEHB brochure
- Blood and blood products (unless included in facility packages)
- Non-prescription medicines
- Internal prosthetics such as heart valves and automatic implantable carioverter defibrillator

Other Covered Services **(This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)**

- Acupuncture
- Hearing Aids
- Health education classes and wellness programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. An individual policy may also provide different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at [contact number] or visit www.opm.gov.insure/health.

Your Appeal 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: [insert applicable contact information from instructions].

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **Coverage under this plan qualifies as minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.**

Language Access Services:

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,120
- **Patient pays** $420

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$320
Coinsurance	$0
Limits or exclusions	$100
Total	**$420**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,770
- **Patient pays** $880

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$550
Coinsurance	$0
Limits or exclusions	$80
Total	**$880**

Questions: Call 671-477-9808 or visit us at www.calvos.net.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.calvos.net or call 671-477-9808 to request a copy.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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