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 73-563) 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.phs.org, and view the Glossary at https://www.healthcare.gov/sbc-glossary/. You can call 1-800-356-2219 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000**/Self Only **$4,000**/Self Plus One **$4,000**/Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Services	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	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.
What is the out-of-pocket limit for this plan?	**$8,150**/person **$16,300**/family	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. **For family coverage, see instructions for additional applicable language.**
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See **www.phs.org** or call 1-855-780-7737 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?	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.

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	First 4 visits: $20 copayment Subsequent visits: 30% coinsurance	Not covered	Visits after the initial 4 visits will be subject to deductible.
	Specialist visit	$50 copayment	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	First 2 visits: $25 copayment/test for diagnostic labs tests and $50 copayment/test for diagnostic basic radiology tests Subsequent visits: 30% coinsurance	Not covered	Visits after the initial 2 visits will be subject to deductible. No charge for first 2 Maternity Ultrasounds; Subsequent visits: 30% coinsurance deductible applies.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Deductible will apply
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.phs.org/fehb	Generic drugs	$10 copayment/ prescription (retail) $20 copayment/ prescription (mail order)	Not covered	Coverage is limited to a 30-day supply up to the maximum dosing recommendation by the manufacturer or FDA maximum recommendation dosage (retail); 90-day supply (mail order)
	Preferred brand drugs	$100 copayment/ prescription (retail) $140 copayment/ prescription (mail order)	Not covered	
	Non-preferred brand drugs	$125 copayment/ prescription (retail) $200 copayment/ prescription (mail order)	Not covered	
	Specialty drugs	50% coinsurance/ prescription up to a	Not covered	Not available (mail order)

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most, plus you may be balance billed)	Limitations, Exceptions, & Other Important Information
		maximum of $500 (retail)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	Prior authorization may be required. Deductible will apply.
	Physician/surgeon fees	30% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	First 2 visits: $300 copayment Subsequent visits: 30% coinsurance	First 2 visits: $300 copayment Subsequent visits: 30% coinsurance	Waived if admitted into a hospital, then hospital copayment applies. Visits after initial 2 visits will be subject to deductible.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Prior authorization may be required for inter-facility services. Deductible will apply.
	Urgent care	$40 copayment/visit	$40 copayment/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Prior authorization may be required. Deductible will apply.
	Physician/surgeon fees	30% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	First 4 visits: $20 copayment Subsequent visits: 30% coinsurance	Not covered	Visits after the initial 4 visits will be subject to deductible.
	Inpatient services	30% coinsurance	Not covered	Prior authorization may be required. Deductible will apply.
If you are pregnant	Office visits	Prenatal Maternity services: $0 copayment Postnatal Maternity services: $40 copayment	Not covered	None
	Childbirth/delivery professional services	0% coinsurance	Not covered	Prior authorization may be required. Delivery services will be subject to deductible.
	Childbirth/delivery facility services	0% coinsurance	Not covered	Prior authorization may be required. Delivery services will be subject to deductible.
If you need help recovering or have	Home health care	30% coinsurance	Not covered	Prior authorization may be required. Deductible will apply.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most, plus you may be balance billed)	Limitations, Exceptions, & Other Important Information
other special health needs	Rehabilitation services	First 60 visits per condition: $20 copayment Subsequent visits: 30% coinsurance	Not covered	Visits after first 60 visits will be subject to deductible.
	Habilitation services	First 60 visits per condition: $20 copayment Subsequent visits: 30% coinsurance	Not covered	Visits after first 60 visits will be subject to deductible.
	Skilled nursing care	30% coinsurance	Not covered	Coverage is limited up to 60 days/calendar year. Prior authorization may be required. Deductible will apply.
	Durable medical equipment	30% coinsurance	Not covered	Prior authorization may be required. Hearing aids are covered for school aged children under 21 if still attending high school every 36 months/hearing impaired ear. Deductible will apply.
	Hospice services	30% coinsurance	Not covered	Prior authorization may be required. Deductible will apply.
If your child needs dental or eye care	Children's eye exam	30% coinsurance	Not covered	Deductible will apply.
If your child needs dental or eye care	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 FEHB Plan brochure for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care (adult)
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine Eye Care (Adult)
- 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 • Weight loss programs	• Chiropractic care	• Hearing aids (for children under 18-21 years of age is still attending high school)

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.insure/health. 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: 505-923-5678 or visit their website at www.phs.org/fehb.

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:
Para obtener asistencia en Español, llame al 1-800-356-2219.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-356-2219.
如果需要中文的帮助，请拨打这个号码 1-800-356-2219.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-356-2219.
Learn more about Presbyterian's Notice of Nondiscrimination, go to www.phs.org/nondiscrimination.aspx.

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	**$2,000**
Specialist	**$50**
Hospital (facility)	**30%**
Other	**30%**

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	$2,000
Copayments	$10
Coinsurance	$2,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,970**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist	**$50**
Hospital (facility)	**30%**
Other	**30%**

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	$1,200
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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

The plan's overall deductible	**$2,000**
Specialist	**$50**
Hospital (facility)	**30%**
Other	**30%**

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	$2,000
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

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