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 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/ or call 1-800-356-2219 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ **0**/Self Only $ **0**/Self Plus One $ **0**/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?	Yes.	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?	$6,350 person/ $12,700 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	$25 copayment/visit adult $0 copayment/visit child	Not covered	No charge for children up to age 26
	Specialist visit	$50 copayment/visit adult $20 copayment/visit child	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$25 copayment/test for diagnostic labs tests and $50 copayment/test for diagnostic basic radiology tests	Not covered	No charge for Maternity Ultrasounds
	Imaging (CT/PET scans, MRIs)	$150 copayment/test	Not covered	Prior authorization may be required.
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 recommended by the manufacturer or FDA maximum recommended 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 maximum of $500 (retail)	Not covered	Not available (mail order)

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copayment/visit	Not covered	Prior authorization may be required. Deductible will apply.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$200 copayment/visit	$200 copayment/visit	Waived if admitted into a hospital, then hospital copayment applies.
	Emergency medical transportation	$50 copayment ground; $100 copayment air; $0 interfacility	$50 copay ground; $100 copay air; $0 interfacility	Prior authorization may be required for inter-facility services.
	Urgent care	$40 copayment/visit adult	$40 copay/visit adult	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$175 copayment/day	Not covered	Prior authorization may be required. Deductible will apply. Maximum copayment of $875 for stays 5 days or longer.
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment/visit adult $0 copayment/visit child	Not covered	None
	Inpatient services	$175 copayment/day	Not covered	Prior authorization may be required. Maximum copayment of $875 for stays 5 days or longer.
If you are pregnant	Office visits	$25 copayment/visit	Not covered	Maximum copayment of $150 per pregnancy.
	Childbirth/delivery professional services	$25 copayment/visit	Not covered	Prior authorization may be required
	Childbirth/delivery facility services	$175 copayment/visit	Not covered	Prior authorization may be required. Maximum copayment of $875 for stays 5 days or longer.
	Home health care	No charge	Not covered	Prior authorization may be required

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 need help recovering or have other special health needs	Rehabilitation services	$50 copayment/visit adult $0 copayment/visit child	Not covered	None
	Habilitation services	$50 copayment/visit adult $0 copayment/visit child	Not covered	None
	Skilled nursing care	$100 copayment/day	Not covered	Coverage is limited up to 60 days/calendar year. Prior authorization may be required. Maximum copayment of $500 for stays 5 days or longer.
	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.
	Hospice services	$100 copayment/day	Not covered	Prior authorization may be required. Maximum copayment of $500 for stays 5 days or longer.
If your child needs dental or eye care	Children's eye exam	$0 copayment PCP $20 copayment Specialist	Not covered	Coverage is limited to refraction eye exam.
	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 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: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 505-923-5678 or visit their website at www.phs.org/fehb.

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** **$0**
- **Specialist** **$50**
- **Hospital (facility)** **$175**
- **Other** **No Cost Sharing**

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	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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** **$50**
- **Hospital (facility)** **$175**
- **Other** **No Cost Sharing**

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	$700
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

- **The plan's overall deductible** **$0**
- **Specialist** **$50**
- **Hospital (facility)** **$175**
- **Other** **No Cost Sharing**

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	**$2,410**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$770**

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