



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](http://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 <a href="#">deductible</a> ?	\$ 500/Self Only \$ 1,000/Self Plus One \$ 1,000/Self and Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. <a href="#">Copayments</a> and <a href="#">coinsurance</a> amounts do not count toward your <a href="#">deductible</a> , which generally starts over January 1. When a covered service/supply is subject to a <a href="#">deductible</a> , only the <a href="#">Plan</a> allowance for the service/supply counts toward the <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$6,350 person/ \$12,700 family	The <a href="#">out-of-pocket limit</a> , or catastrophic maximum, is the most you could pay in a year for covered services. <b>For family coverage, see instructions for additional applicable language.</b>
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.phs.org">www.phs.org</a> or call 1-855-780-7737 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copayment</a> /visit	Not covered	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copayment</a> /visit	Not covered	None
	<a href="#">Preventive care/screening</a> /immunization	No charge	Not covered	None
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$25 <a href="#">copayment</a> /test for diagnostic labs tests and \$50 <a href="#">copayment</a> /test for diagnostic basic radiology tests	Not covered	No charge for Maternity Ultrasound
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copayment</a> /test	Not covered	Prior authorization may be required.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.phs.org/fehb">www.phs.org/fehb</a> .	Generic drugs	\$10 <a href="#">copayment</a> /prescription (retail); \$20 <a href="#">copayment</a> /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 <a href="#">copayment</a> /prescription (retail); \$140 <a href="#">copayment</a> /prescription (mail order)	Not covered	
	Non-preferred brand drugs	\$125 <a href="#">copayment</a> /prescription (retail); \$200 <a href="#">copayment</a> /prescription (mail order)	Not covered	
	<a href="#">Specialty drugs</a>	50% <a href="#">coinsurance</a> prescription up to a maximum of \$500 (retail)	Not covered	Not available (mail order)
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	Not covered	Prior authorization may be required. <a href="#">Deductible</a> will apply. \$2,000 maximum <a href="#">out-of-pocket</a> responsibility per surgery.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	

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 immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copayment</a> /visit	\$250 <a href="#">copayment</a> /visit	Waived if admitted into a hospital, then hospital <a href="#">copayment</a> applies.
	<a href="#">Emergency medical transportation</a>	\$50 <a href="#">copayment</a> ground; \$100 <a href="#">copayment</a> air; \$0 interfacility	\$50 <a href="#">copayment</a> ground; \$100 <a href="#">copayment</a> air; \$0 interfacility	Prior authorization may be required for inter-facility services.
	<a href="#">Urgent care</a>	\$40 <a href="#">copayment</a> /visit	\$40 <a href="#">copayment</a> /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	Not covered	Prior authorization may be required. <a href="#">Deductible</a> will apply. \$2,000 maximum out of pocket responsibility per stay.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copayment</a> /visit	Not covered	None
	Inpatient services	30% <a href="#">coinsurance</a>	Not covered	Prior authorization may be required. <a href="#">Deductible</a> will apply. \$2,000 maximum <a href="#">out-of-pocket</a> responsibility per stay.
If you are pregnant	Office visits	\$30 <a href="#">copayment</a> /visit	Not covered	Coverage is limited to a max of \$300 in <a href="#">copayments</a> per pregnancy.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> will apply. Prior authorization may be required.
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	Not covered	Prior authorization may be required. <a href="#">Deductible</a> will apply. \$2,000 maximum <a href="#">out-of-pocket</a> responsibility per stay.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	Not covered	Prior authorization may be required
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copayment</a> /visit	Not covered	Coverage is limited to 2 months per condition. Prior authorization maybe required.
	<a href="#">Habilitation services</a>	\$30 <a href="#">copayment</a> /visit	Not covered	
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	Not covered	Coverage is limited up to 60 days/calendar year. Prior authorization may be required. <a href="#">Deductible</a> will apply.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	Not covered	Prior authorization may be required. Hearing aids are covered for school aged children under 21 if still attending high school every 36

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)	
				months/hearing impaired ear. <a href="#">Deductible</a> will apply.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	Not covered	Prior authorization may be required. <a href="#">Deductible</a> will apply.
If your child needs dental or eye care	Children's eye exam	\$0 <a href="#">copayment</a> PCP \$20 <a href="#">copayment</a> Specialist	Not covered	Coverage is limited to refraction exams for children age 0-6.
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 <a href="#">Plan</a> Generally Does NOT Cover (Check your FEHB <a href="#">Plan</a> brochure for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (adult)</li> <li>• Long-term Care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> <li>• Routine Eye Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB <a href="#">Plan</a> brochure.)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Weight loss programs</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (for children under 18-21 years of age is still attending high school)</li> </ul>

**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](http://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](http://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](http://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, kwijigo holne' 1-800-356-2219.

Learn more about Presbyterian's Notice of Nondiscrimination, go to [www.phs.org/nondiscrimination.aspx](http://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 <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a>	\$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$2,400
<a href="#">Coinsurance</a>	\$2,500
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,460</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a>	\$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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$300
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,520</b>

### Mia's Simple Fracture

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

■ The plan's overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a>	\$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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>