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 PSHB Plan brochure 73-913 that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the** PSHB 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 PSHB Plan brochure at www.carefirst.com/pshbp, and view the Glossary at www.carefirst.com/pshbp. You can call 1-833-489-1316 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network $1,650 self only $3,300 self plus one $3,300 self and family Out-of-Network $3,300 self only $6,600 self plus one $6,600 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, all In-Network preventive care 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. Prescription Drug **deductible** is combined with Medical. There are no other specific **deductibles**.	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?	Medical and Prescription Drug combined: In-Network: $5,500 self only $11,000 self plus one $11,000 self and family; Out-of-Network $7,500 self only $15,000 self plus one $15,000 self and family	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Plan premiums, health care services that plan does not cover, balance-billed over allowed amount and durable medical equipment.	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 http://www.carefirst.com/pshbp or call 833-489-1316 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?	No.	You can see the specialist you choose without a referral.

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	No Charge	$80 copay per visit	Virtual Connect through CloseKnit available at $0 cost share to members 18 and over; HSA qualified plans are subject to the required deductible. (closeknithealth.com) Member is responsible for any amount over our allowed amount when seeing out-of-network provider in addition to the applicable copay.
	Specialist visit	$35 copay per visit	$80 copay per visit	Member is responsible for any amount over our allowed amount when seeing out-of-network provider in addition to the applicable copay.
	Retail Health Clinic	Deductible, then No Charge	Deductible, then $80 copay per visit	Deductible applies to all out-of-network services. Member is responsible for any amount over our allowed amount when seeing out-of-network provider in addition to the applicable copay.

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)	
	Preventive care/screening/ immunization	No Charge	Deductible, then No Charge	Deductible applies to all out-of-network services. Member is responsible for any amount over our allowed amount when seeing out-of-network provider in addition to the applicable copay.
If you have a test	Diagnostic test (x-ray, blood work)	Lab tests: Non-Hospital: Deductible, then No Charge Outpatient Hospital: Deductible, then $35 copay per visit X-rays: Non-Hospital: Deductible, then $35 copay per visit Outpatient Hospital: Deductible, then $50 copay per visit	Lab tests & X-rays: Non-Hospital: Deductible, then 20% of Plan Allowance Outpatient Hospital: Deductible, then 30% of Plan Allowance	HMO prior authorization is required at a hospital; nothing for tests such as blood tests, urinalysis, routine pap tests, pathology, x-rays at preferred network providers. Copay and/or coinsurance will apply at other providers.
	Imaging (CT/PET scans, MRIs)	Non-Hospital: Deductible, then $75 copay per visit Outpatient Hospital: Deductible, then $100 copay per visit	Non-Hospital: Deductible, then 20% of Plan Allowance Outpatient Hospital: Deductible, then 30% of Plan Allowance	Deductible applies to all out-of-network services. Member is responsible for any amount over our allowed amount when seeing out-of-network provider in addition to the applicable copay.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com/pshbp	Generic drugs	Deductible, then No Charge (34-day supply) Deductible, then No Charge (90-day supply)	Not Covered	Deductible applies to all generic drugs except for preferred generics that treat asthma, blood pressure, cholesterol, depression and diabetes. Call CareFirst Pharmacy Member Services with questions at 1-800-241-3371.
	Preferred brand drugs	Deductible, then $50 copay (34-day supply) Deductible, then $100 copay (90-day supply)	Not Covered	Deductible applies to all drugs. Call CareFirst Pharmacy Member Services with questions at 1-800-241-3371.
	Non-preferred brand drugs	Deductible, then $75 copay (34-day supply) Deductible, then $150 copay (90-day supply)	Not Covered	Deductible applies to all drugs. Call CareFirst Pharmacy Member Services with questions at 1-800-241-3371.
	Preferred Specialty drugs	Deductible, then $100 copay (34-day supply) Deductible, then $200 copay (90-day supply)	Not Covered	Drugs must be pre-approved and preferred pharmacies must be used.
	Non-preferred Specialty drugs	Deductible, then $150 copay (34-day supply) Deductible, then $300 copay (90-day supply)	Not Covered	Drugs must be pre-approved and preferred pharmacies must be used.

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)	Non-Hospital: Deductible, then $100 copay per visit Hospital: Deducible, then $300 copay per visit	Non-Hospital & Hospital Deductible, then $500 copay per visit	Procedures may be subject to medical review. ASC is Ambulatory Surgical Center.
	Physician/surgeon fees	Non-Hospital & Hospital PCP: No Charge Specialist: $35 copay per visit	Non-Hospital & Hospital $80 copay per visit	Procedures may be subject to medical review.
If you need immediate medical attention	Emergency room care	$300 copay per visit	Paid as In-Network	For urgent situations, please call your primary care physician or FirstHelp at 1-800-535-9700. Copay waived if admitted.
	Emergency medical transportation	Deductible, then $100 copay per transport	Deductible, then $150 copay per transport	For urgent situations, please call your primary care physician or FirstHelp at 1-800-535-9700.
	Urgent care	$50 copay per visit	$50 copay per visit	For urgent situations, please call your primary care physician or FirstHelp at 1-800-535-9700.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Plan Allowance	Deductible, then 30% of Plan Allowance	All non-emergency admissions must be pre-authorized.

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)	
	Physician/surgeon fees	Deductible, then 20% of Plan Allowance	Deductible, then 30% of Plan Allowance	Member is responsible for all changes over our allowed amount. Coverage subject to medical policy guideline.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: No Charge Outpatient Hospital Facility: Deductible, then $100 copay per visit	Office Visit: $80 copay per visit Outpatient Hospital Facility: Deductible, then $150 copay per visit	Virtual Connect through CloseKnit available at $0 cost share to members 18 and over; HSA qualified plans are subject to the required deductible. (closeknithealth.com) Our in-network providers are part of Magellan Behavioral Health 1-800-245-7013.
	Inpatient services	Deductible, then 20% of Plan Allowance	Deductible, then 30% of Plan Allowance	Inpatient care must be authorized by calling 1-800-245-7013.
If you are pregnant	Office visits	No Charge	Deductible, then No Charge	No copay for routine maternity care.
	Childbirth/delivery professional services	Deductible, then 20% of Plan Allowance	Deductible, then 30% of Plan Allowance	Coverage subject to medical policy guidelines

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 facility services	Deductible, then 20% of Plan Allowance	Deductible, then 30% of Plan Allowance	Maternity admissions do not require pre-certification.
If you need help recovering or have other special health needs	Home health care	$35 copay per visit	$80 copay per visit	Service must be pre-approved
	Rehabilitation services	$35 copay per visit	$80 copay per visit	Service must be pre-approved
	Habilitation services	Deductible, then $35 copay per visit	Deductible, then $80 copay per visit	Coverage only applies to physical, speech and occupational therapy for children with specified childhood conditions. Care must be medically necessary, but visit limits do not apply.
	Skilled nursing care	20% of Plan Allowance per admission	30% of Plan Allowance per admission	Service must be pre-approved
	Durable medical equipment	Deductible, then 25% of Plan Allowance per device/item	Deductible, then 25% of Plan Allowance per device/item	Service must be medically necessary.
	Hospice services	Inpatient Care: Deductible, then $35 copay per admission Outpatient Care: Deductible, then $35 copay per visit	Inpatient Care: Deductible, then $80 copay per admission Outpatient Care: Deductible, then $80 copay per visit	Service must be pre-approved and may have limits. See on-line brochure.

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 your child needs dental or eye care	Children's eye exam	$10 copay per visit at Davis Vision Providers	Member pays expenses in excess of $33 Allowed Benefit	Routine eye care for children may be covered.
	Children's glasses	Not Covered	Not Covered	This is a Non-PSHBP program
	Children's dental check-up	Not Covered	Not Covered	Discount program available to all members.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your PSHB 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 of the U.S.
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your PSHB Plan brochure.)

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Most coverage provided outside of the U.S. See www.carefirst.com/pshbp
- Routine eye care (Adult)
- Routine foot care
- Weight loss program

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the PSHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-833-489-1316 or visit www.health-benefits.opm.gov/pshb. 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-PSHB 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 PSHB Plan brochure. If you need assistance, you can contact: your plan at 1-833-489-1316.

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:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-318-2596
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-318-2596
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-318-2596
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-318-2596

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	$1,650
Specialist Copayment	$35
Hospital (facility) Coinsurance	20%
Other Copayment	$0

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	$1,650
Copayments	$0
Coinsurance	$1,670
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$3,330**

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

The plan's overall deductible	$1,650
Specialist Copayment	$35
Hospital (facility) Coinsurance	20%
Other Coinsurance	25%

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	$1,650
Copayments	$500
Coinsurance	$145
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,295**

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

The plan's overall deductible	$1,650
Specialist Copayment	$35
Hospital (facility) Copayment	$300
Other Copayment	$35

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	$1,650
Copayments	$245
Coinsurance	$68
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,963**

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