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 73-884 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.priorityhealth.com\FEHB, and view the Glossary at www.priorityhealth.com\FEHB You can call 1-800-446-5674 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 1,500/Self Only $ 3,000/Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible
Are there services covered before you meet your deductible?	Yes: preventive care, PCP office visits.	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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,350/$14,700	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met
What is not included in the out-of-pocket limit?	Premiums, balanced-billed charges, care this plan does not cover and services that exceed an annual day/visit limit	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 PriorityHealth.com or call 1-800-446-5674 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 don't need a referral in order to receive serviced provided by a participating specialist.	You can see the in-network specialist you choose without a referral. This plan will pay some or all of the costs to see an out-of-network 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: 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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-pay	Not covered	No charge for evaluation and management services only when provided during PCP visits or routine maternity prenatal and post natal care. Deductible does not apply. Gene Therapy will be covered at 100% with no deductible applying when done in an in-network physician's office. If billed as outpatient or inpatient, the outpatient or inpatient hospital benefit will apply. Deductible applies.
	Specialist visit	$35 co-pay	Not Covered	Deductible applies.
	Preventive care/screening/ immunization	No Charge	Not Covered	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not Covered	--------------none-----------
	Imaging (CT/PET scans, MRIs)	$150 co-pay	Not Covered	Prior Approval required for certain radiology examinations.

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
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.priorityhealth.com\FEHB	Generic drugs	$20 co-pay/ retail prescriptions $40 co-pay/ mail order prescription	Not Covered	Costs shown in the "What You Will Pay" columns apply to drugs on the approved drug list when obtained from a Participating Provider. Covers up to a 31-day supply (retail prescription); Covers up to a 90 day supply (mail order prescription) Up to a 90-day supply of medication (excluding Specialty Drugs) may be obtained at one time for three applicable Copayments at a retail Participating Pharmacy. 50% co-insurance/ prescription for infertility drugs. Deductible does not apply
	Preferred brand drugs	$60 co-pay/ retail prescriptions $120 co-pay/ mail order prescription	No Covered	
	Non-preferred brand drugs	$90 co-pay/ retail prescriptions $180 co-pay/ mail order prescription	Not Covered	
	Specialty drugs	20% co-insurance/ retail prescription	Not Covered	The maximum co-pay for preferred specialty drugs is $200 per fill. The maximum co-pay for non-preferred specialty drugs is $400 per fill.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not Covered	Including outpatient care, observation care and ambulatory surgery center care. Prior approval may be required. Prior approval is required for bariatric surgery.
	Physician/surgeon fees	10% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	$200 co-pay/ visit	Covered at the in-network benefit level	Co-pay waived if you become confined in a Hospital as an inpatient. Deductible applies.
	Emergency medical transportation	$150 co-pay	Covered at the in-network benefit level	----------none---------
	Urgent care	$75 co-pay/ visit	Covered at the in-network benefit level when obtained outside the service area	Urgent Care services received from a Non-Participating Provider who is located in our Service Area are not Covered. Urgent Care services received from a Non-Participating Provider who is located outside of our

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)	
				Service Area are Covered. Deductible applies
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not Covered	Prior Approval is required at least 5 working days in advance, except in emergencies or for Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Notification must be provided for all admissions following emergency room care. Prior approval is required for bariatric surgery.
	Physician/surgeon fees	10% coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	Not Covered	Including medication management visits.
	Inpatient services	10% coinsurance	Not Covered	Including subacute and partial hospitalization. Except in an emergency, prior approval required.
If you are pregnant	Office visits	No Charge	Not Covered	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. Appropriate office visit charge (PCP or specialist) may apply for physician office services or home visits and consultations for complications of pregnancy.
	Childbirth/delivery professional services	10% coinsurance	Not Covered	------------none-----------
	Childbirth/delivery facility services	10% coinsurance	Not Covered	------------none-----------
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Including hospice care services; excluding rehabilitation and habilitation services. Prior approval required except for hospice care services in the home.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most, plus you may be balance billed)	Limitations, Exceptions, & Other Important Information
				Rehabilitation and habilitation services provided in the home are subject to the limitations of the Rehabilitation Services and Habilitation Services benefits described below.
	Rehabilitation services	$10 co-pay	Not Covered	Physical and occupational therapy (Including osteopathic and chiropractic manipulation) limited to a combined 60 visits per contract year. Speech therapy limited to a combined 60 visits per contract year. Cardiac rehabilitation & pulmonary rehabilitation limited to a combined 60 visits per contract year.
	Habilitation services	$10 copayment per visit Applied Behavioral Analysis (ABA) services	Not Covered	Prior Approval required for Applied Behavioral Analysis (ABA). Services are Covered for children and adolescents under age 19 only. Multiple charges may apply during one day of service.
	Skilled nursing care	10% coinsurance	Not Covered	Services received in a skilled nursing care facility, subacute facility, or hospice care facility are limited to a combined 45 days per contract year. Prior approval required
	Durable medical equipment	50% co-insurance	Not Covered	Including rental, purchase or repair. Prior Approval required for equipment over $1,000, all rentals and all shoe inserts. No charge for diabetic supplies. Deductible applies.
	Hospice services	No Charge	Not Covered	This benefit applies to hospice services provided in the home only. Any hospice services provided in a facility

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
				will be subject to the appropriate facility benefit.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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.)

- Acupuncture
- Cosmetic Surgery
- Dental care (Adult & Child)
- Habilitation services not for the treatment of Autism Spectrum Disorder.
- Hearing Aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care

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

- Bariatric surgery
- Chiropractic care
- Infertility treatment - diagnostic, counseling and planning services for the underlying cause of
- infertility
- Weight loss programs

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 1-800-446-5674 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: 1-800-446-5674.

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 1-800-446-5674
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-446-5674
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-446-5674
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-446-5674

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

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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	**$1,500**
Specialist	**$35**
Hospital (facility)	**10%**
Other	**10%**

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	$1,500
Copayments	$100
Coinsurance	$1,240
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,900**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	**$1,500**
Specialist	**$35**
Hospital (facility)	**10%**
Other	**10%**

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	$1,500
Copayments	$1,550
Coinsurance	$13
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,123**

Mia's Simple Fracture

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

The plan's overall deductible	**$1,500**
Specialist	**$35**
Hospital (facility)	**10%**
Other	**10%**

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	$1,500
Copayments	$554
Coinsurance	$102
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,156**

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