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 ([insert brochure number]) 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.MHBPPostal.com, and view the Glossary at www.MHBPPostal.com. You can call 1-833-497-2416 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $800/Self Only $1,600/Self Plus One $1,600/Self and Family Network providers: $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. 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/wellness; office visits; urgent care visits and preventive prescriptions.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet other deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network providers: $10,000/Self Only; $20,000/Self Plus One or Self and Family ($10,000 per covered individual). Non-network providers: $12,000/Self Only; $24,000/Self Plus One or Self and Family ($12,000 per covered individual)	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this plan, they must 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, balance-billed charges, penalties, expenses covered by specialty drug copayment assistance cards, and non-covered services.	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.MHBPPostal.com or call 1-833-497-2416 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 a non-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 a non-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.	This plan does not require a referral to see a specialist for covered services.



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	$40 copayment per visit	40% coinsurance of the Plan allowance	Network: No deductible. Non-Network: Plus any difference between our allowance and the billed amount.
	Specialist visit	$50 copayment per visit	40% coinsurance of the Plan allowance	Non-Network: Plus any difference between our allowance and the billed amount.
	Preventive care/screening/ immunization	No charge	40% coinsurance of the Plan allowance	Network: No deductible. Non-Network: Plus any difference between our allowance and the billed amount.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance of the Plan allowance	Non-Network: Plus any difference between our allowance and the billed amount.
	Lab Savings Program	No charge	Not covered	Network: No deductible.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance of the Plan allowance	Prior approval is required. Non-Network: Plus any difference between our allowance and the billed amount.

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.MHBPPostal.com	Generic drugs	$10 copayment for up to a 30-day supply (retail) $30 copayment for a 31 - 90-day supply (mail)	Not covered	No deductible.
	Preferred brand drugs	45% coinsurance of Plan's allowance; limited to $300 for up to a 30-day supply (retail) and $500 for a 31 - 90-day supply (mail)	Not covered	No deductible. Network: Plus any difference between the cost of a generic and brand equivalent, unless a brand exception is obtained.
	Non-preferred brand drugs	75% coinsurance of Plan's allowance for up to a 30-day supply (retail) and 31 - 90-day supply (mail)	Not covered	No deductible. Network: Plus any difference between the cost of a generic and brand equivalent, unless a brand exception is obtained.
	Anti-obesity medications	50% coinsurance of Plan's allowance for up to a 30-day supply (retail) and 31 - 90-day supply (mail)	Not covered	No deductible. Network: Plus any difference between the cost of a generic and brand equivalent, unless a brand exception is obtained. Must enroll in our Weight Management Program before coverage for the medication will begin and must stay engaged to obtain at our plan-designated cost share.
	Specialty drugs (Generic)	50% coinsurance of the Plan's allowance; limited to $600 for up to a 30-day supply and $800 for a 31 - 90-day supply	Not covered	No deductible. Specialty drugs must be obtained through CVS Caremark Specialty Pharmacy. Preauthorization is required.
	Specialty drugs (Preferred brand)			
	Specialty drugs (Non-Preferred brand)	50% coinsurance of the Plan's allowance for up to a 90-day supply	Not covered	No deductible. Specialty drugs must be obtained through CVS Caremark Specialty Pharmacy. Preauthorization is 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance of the Plan allowance	Non-Network: Plus any difference between our allowance and the billed amount.
	Physician/surgeon fees	20% coinsurance	40% coinsurance of the Plan allowance	Non-Network: Plus any difference between our allowance and the billed amount.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance of the Plan allowance	Non-Network: Plus any difference between our allowance and the billed amount.
	Emergency medical transportation	20% coinsurance	20% coinsurance of the Plan allowance	Non-Network: Plus any difference between our allowance and the billed amount.
	Urgent care	20% coinsurance	40% coinsurance of the Plan allowance	Network: No deductible. Non-Network: Plus any difference between our allowance and the billed amount.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance of the Plan allowance	Precertification is required; $500 penalty for non-compliance. Non-Network: Plus any difference between our allowance and the billed amount.
	Physician/surgeon fees	20% coinsurance	40% coinsurance of the Plan allowance	Non-Network: Plus any difference between our allowance and the billed amount.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copayment per visit; 20% coinsurance for other outpatient services	40% coinsurance of the Plan allowance	Prior approval is required for certain outpatient services. Network: No deductible. Non-Network: Plus any difference between our allowance and the billed amount.
	Inpatient services	20% coinsurance	40% coinsurance of the Plan allowance	Precertification is required; $500 penalty for non-compliance. Network: No deductible. Non-Network: Plus any difference between our allowance and the billed amount.
If you are pregnant	Office visits	No charge	40% coinsurance of the Plan allowance	Network: Preventive care services are covered at 100%, no deductible. Non-Network: Plus any difference between our allowance and the billed amount.

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 professional services	20% coinsurance	40% coinsurance of the Plan allowance	Non-Network: Plus any difference between our allowance and the billed amount.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance of the Plan allowance	Non-Network: Plus any difference between our allowance and the billed amount.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance of the Plan allowance	Limited to 25 visits per year. Non-Network: Plus any difference between our allowance and the billed amount.
	Rehabilitation services	20% coinsurance	40% coinsurance of the Plan allowance	Limited to 40 visits per year for combined physical, occupational and speech therapies. Non-Network: Plus any difference between our allowance and the billed amount.
	Habilitation services	20% coinsurance	40% coinsurance of the Plan allowance	Non-Network: Plus any difference between our allowance and the billed amount.
	Skilled nursing care	20% coinsurance	40% coinsurance of the Plan allowance	Prior approval is required. Limited to 40 days in a skilled nursing facility (SNF) per year, covered only when the Plan is the primary payor. Non-Network: Plus any difference between our allowance and the billed amount.
	Durable medical equipment	20% coinsurance	40% coinsurance of the Plan allowance	Non-Network: Plus any difference between our allowance and the billed amount.
	Hospice services	20% coinsurance	40% coinsurance of the Plan allowance	Non-Network: Plus any difference between our allowance and the billed amount.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Excluded
	Children's glasses	All charges over $50	All charges over $50	Must be related to an accidental injury or intraocular surgery
	Children's dental check-up	Not covered	Not covered	Excluded

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
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (Except for members with an established diagnosis of diabetes or peripheral vascular disease)

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
- Non-emergency care when traveling outside the U.S.
- 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 1-833-497-2416 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 customer service at 1-833-497-2416.

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 1-833-497-2416.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-497-2416.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-497-2416.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-497-2416.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-833-497-2416.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-497-2416.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-497-2416.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-833-497-2416.

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** **$800**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$800
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,770**

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

- **The plan's overall deductible** **$800**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$3,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,920**

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

- **The plan's overall deductible** **$800**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$800
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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