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 (RI 71-012) 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.rcbphealth.com and view the Glossary at www.rcbphealth.com. You can call 1-800-638-8432 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $350/Self Only $700/Self Plus One $700/Self and Family Out-of-network: $800/Self Only $1,600/Self Plus One $1,600/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. 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. In-network preventive care; In-network office visits, In-network; inpatient hospital; In-network surgery; Emergency services; and 90-day supply of prescription drugs.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $200 per person for retail prescriptions. Retail deductible is waived when Medicare Part A and B are primary. $50 per person for dental coverage for all services except for preventive services.	You must pay all 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?	In-network providers: $5,000/Self Only $10,000/Self Plus One or Self and Family Out-of-network providers: $7,000/Self Only $14,000/Self Plus One or Self and Family	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.

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What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, dental expenses, 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.rcbphealth.com or call 1-800-638-8432 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.	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, including CVS Minute Clinics	$20 copayment	30% coinsurance	Deductible applies to out-of-network providers. Professional services of a physician outside the office setting are 15% coinsurance subject to deductible for network services.
	Specialist visit	$35 copayment	30% coinsurance	Deductible applies to out-of-network providers. Professional services of a physician outside the office setting are 15% coinsurance subject to deductible for network services.
	Preventive care/screening/ Immunization	No charge	30% coinsurance	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.
	Professional non-emergency services	Walk-in Clinic: $20 copayment	30% coinsurance	

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If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	30% coinsurance	Deductible applies to In and out-of-network.
	Lab Savings Program	No charge	Not available	For covered lab tests performed by Quest Diagnostics or LabCorp.
	Imaging (CT/PET scans, MRIs)	5% coinsurance at a stand-alone network imaging center or clinic; 15% coinsurance at other providers	30% coinsurance	Deductible applies to In and out-of-network. Prior approval is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.rcbphealth.com	Generic drugs	$200 per person retail deductible then 30% coinsurance; maximum $7.50 Mail: $10 copayment	$200 per person retail deductible then 30% coinsurance Mail not covered	Max 34-day (retail)/90-day (mail). After 3 retail fills, maintenance drugs are only covered at mail or retail CVS pharmacy.
	Preferred brand drugs	$200 per person retail deductible then 30%; maximum $200 Mail: $50 copayment	$200 per person retail deductible then 30% Mail not covered	Max 34-day (retail)/90-day (mail). After 3 retail fills, maintenance drugs are only covered at CVS Caremark mail service pharmacy or at a retail CVS pharmacy.
	Non-preferred brand drugs	$200 per person retail deductible then 30% coinsurance; maximum $200 Mail: $80 copayment	$200 per person retail deductible then 30% coinsurance Mail not covered	Max 34-day (retail)/90-day (mail). After 3 retail fills, maintenance drugs are only covered at CVS Caremark mail service pharmacy or at a retail CVS pharmacy.

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If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.rcbphealth.com	Specialty Generic drugs	$200 per person retail deductible then $70 copayment for a 30-day supply; $100 copayment for a 90-day supply	Mail not covered	Specialty drugs must be obtained through CVS Caremark Specialty Pharmacy. Preauthorization is required.
	Specialty Preferred drugs	$200 per person retail deductible then $90 copayment for a 30-day supply; $125 copayment for a 90-day supply	Mail not covered	Specialty drugs must be obtained through CVS Caremark Specialty Pharmacy. Preauthorization is required.
	Specialty Non-Preferred drugs	Specialty: $120 copayment for a 30-day supply; $250 copayment for a 90-day supply	Mail not covered	Specialty drugs must be obtained through CVS Caremark Specialty Pharmacy. Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	30% coinsurance	Deductible applies in and out-of-network.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	Deductible applies to out-of-network providers.
If you need immediate medical attention	Emergency room care	Accident: No charge; Medical emergency: $200 copayment	Accident: Difference between Plan allowance and billed amount. Medical emergency: $200 copayment	
	Emergency medical transportation	15% coinsurance	15% coinsurance	
	Urgent care	$35 copayment per visit	30% coinsurance	Deductible applies to out-of-network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copayment per admission	$400 copayment per admission and 30% coinsurance	Precertification is required.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	Deductible applies to out-of-network physician and surgeon.

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If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment per primary care visit; 15% coinsurance for all other services	30% coinsurance	Deductible applies to out-of-network office visits and outpatient services. Certain services require prior approval.
	Inpatient services	$200 copayment per admission	30%coinsurance	Precertification is required.
If you are pregnant	Office visits	No charge	30% coinsurance	Deductible applies to out-of-network.
	Childbirth/delivery professional services	No charge	30% coinsurance	Deductible applies to out-of-network.
	Childbirth/delivery facility services	No charge	$400 copayment per admission and 30% coinsurance	Deductible applies to out-of-network.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	30% coinsurance	Limit 90 visits per year.
	Rehabilitation services	15% coinsurance	30% coinsurance	Limited to 90 visits per year combined. Deductible applies In and out-of-network.
	Habilitation services	15% coinsurance	30% coinsurance	Deductible applies In and out-of-network.
	Skilled nursing care	$200 copayment per admission	$400 copayment per admission and 30% coinsurance	Precertification is required. Limited to 60 days per calendar year.
	Durable medical equipment	15% coinsurance	30% coinsurance	Deductible applies.
	Hospice services	15% coinsurance	30% coinsurance	
If your child needs dental or eye care	Children's eye exam	All charges over $45	All charges over $45	Benefit limited to $45 for routine eye exam.
	Children's glasses	15% coinsurance	30% coinsurance	Cover one pair of glasses with standard frames and must be related to an accidental injury or intraocular surgery. Deductible applies.
	Children's dental check-up	No charge for two preventive care exams per person per year	No charge for two preventive care exams per person per year	Member pays all charges exceeding Plan's scheduled allowance for the service.

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For more information about limitations and exceptions, see the PSHB Plan brochure RI 72-012 at www.rcbphealth.com.

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
- Custodial care
- Long-term care
- Private-duty nursing
- Routine foot care

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 services
- Licensed Doula support
- Massage therapy
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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 1-800-638-8432 or visit https://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), spouseequity 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 1-800-638-8432.

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 1-800-638-8432.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-638-8432.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-638-8432.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-638-8432.]

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** **$350**
- **Specialist *[cost sharing]*** **$35**
- **Hospital (facility) *[cost sharing]*** **$0**
- **Other *[cost sharing]*** **15%**

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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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

- **The plan's overall deductible** **$350**
- **Specialist *[cost sharing]*** **$35**
- **Hospital (facility) *[cost sharing]*** **$0**
- **Other *[cost sharing]*** **15%**

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	$200
Copayments	$3,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,300**

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

- **The plan's overall deductible** **$350**
- **Specialist *[cost sharing]*** **$35**
- **Hospital (facility) *[cost sharing]*** **$0**
- **Other *[cost sharing]*** **15%**

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	$400
Copayments	$70
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$570**

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