



Coverage for: Self Only, Self Plus One or Self and Family | Plan Type: HMO

 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 73-928 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.MedMutual.com/PSHB and view the Glossary at www.MedMutual.com/PSHB SBC. You can call 1-800-315-3144 to request a copy of either document.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall <u>deductible</u> ? | \$0/Self Only \$ 0/Self Plus One \$ 0/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 <u>deductible</u> ? | Yes. Certain <u>preventive care</u> and all services with <u>copayments</u> are covered and paid by the <u>plan</u> before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | Not Applicable | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | \$ 6,000/Self Only \$ 12,000/Self Plus One \$ 12,000/Self and Family | The <u>out-of-pocket limit</u> , or <u>catastrophic maximum</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u> ? | <u>Premiums</u> , balance-billed charges and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |

| | | |
|--|---|---|
| Will you pay less if you use a <u>network provider</u>? | Yes. See MedMutual.com/PSHB or call 1-800-315-3144 for a list of <u>network providers</u> . | 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 <u>referral</u> to see a <u>specialist</u>? | 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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$25 copay/visit at PCP office | Not covered | None |
| | <u>Specialist</u> visit | \$45 copay/visit at <u>Specialist</u> office | Not covered | None |
| | <u>Preventive care/screening/immunization</u> | No charge | Not covered | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No charge | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | No charge | Not covered | None |

For more information about limitations and exceptions, see the PSHB Plan brochure RI 73-928 at www.MedMutual.com/PSHB.

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|---|--|--|--|--|
| | | 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 MedMutual.com/PSHB | Generic retail | \$10 copay | Not covered | Covers up to a 30-day supply. |
| | Generic mail order | \$20 copay | Not covered | Covers up to a 90-day supply. |
| | Preferred brand retail | \$75 copay | Not covered | Covers up to a 30-day supply. |
| | Preferred brand drugs | \$150 copay | Not covered | Covers up to a 90-day supply. |
| | Non-preferred brand drugs retail | 60% with a max of \$180 copay | Not Covered | Covers up to a 30-day supply. |
| | Non-preferred brand mail order | 60% with a max of \$360 copay | Not Covered | Covers up to a 90-day supply. |
| | <u>Specialty drugs</u> | 25% up to \$500 max per prescription or refill | Not Covered | Covers up to a 30-day supply |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$375 copay/visit | Not Covered | None |
| | Physician/surgeon fees | \$25 copay/visit (PCP); \$45 copay/visit (Specialist) | Not Covered | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$325 copay/visit | \$325 copay/visit | None |
| | <u>Emergency medical transportation</u> | \$350 copay | \$350 copay | None |
| | <u>Urgent care</u> | \$35 copay/visit | Not covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$650 copay | Not covered | None |
| | Physician/surgeon fees | No charge | Not covered | None |

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| | | 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 mental health, behavioral health, or substance abuse services | Outpatient services | \$25 copay/visit for individual therapy | Not covered | None |
| | Inpatient services | \$650 copay/admission | Not covered | None |
| If you are pregnant | Office visits | No charge | Not covered | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, copay, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., Ultrasound). |
| | Childbirth/delivery professional services | No charge | Not covered | None |
| | Childbirth/delivery facility services | No charge | Not covered | None |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No charge | Not covered | None |
| | <u>Rehabilitation services</u> (Physical Therapy) | \$25 copay/visit | Not covered | (60 visits per benefit period, combined with Occupational Therapy) |
| | <u>Habilitation services</u> (Occupational Therapy) | \$25 copay/visit | Not covered | (60 visits per benefit period, combined with Physical Therapy) |
| | <u>Habilitation services</u> (Speech) | \$25 copay/visit | Not covered | (60 visits per benefit period) |
| | <u>Skilled nursing care</u> | No charge | Not covered | (100 days per benefit period) |
| | <u>Durable medical equipment</u> | 25% <u>coinsurance</u> | Not covered | None |
| If your child needs dental or eye care | <u>Hospice services</u> | No charge | Not covered | None |
| | Children's eye exam | No charge | Not covered | None |
| | Children's glasses | Not covered | Not covered | Excluded Service |
| | Children's dental check-up | Not covered | Not covered | Excluded Service |

For more information about limitations and exceptions, see the PSHB Plan brochure RI 73-928 at www.MedMutual.com/PSHB.

Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your PSHB Plan brochure for more information and a list of any other <u>excluded services</u> .) | | |
|--|--|--|
| <ul style="list-style-type: none">• Acupuncture• Children’s dental check-up• Children’s glasses | <ul style="list-style-type: none">• Cosmetic Surgery• Dental Care• Hearing Aids (Adult)• Long-Term Care• Non-emergency care when traveling outside the U.S | <ul style="list-style-type: none">• Private-Duty Nursing• Routine Eye Care (Adult)• Routine Foot Care• Weight Loss Programs |
| Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your PSHB Plan brochure.) | | |
| <ul style="list-style-type: none">• Bariatric Surgery• Infertility Treatment• Chiropractic Care | | |

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 1-800-315-3144 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), 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 1-800-315-3144.

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.

For more information about limitations and exceptions, see the PSHB Plan brochure RI 73-928 at www.MedMutual.com/PSHB .

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-315-3144.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-315-3144.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-315-3144.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-315-3144.

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 \$0
- Specialist [cost sharing] \$45
- Hospital (facility) [cost sharing] \$650
- Other [cost sharing] 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|-------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$70 |

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

- The plan's overall deductible \$0
- Specialist [cost sharing] \$45
- Hospital (facility) [cost sharing] \$650
- Other [cost sharing] 0%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$900 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$920 |

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

- The plan's overall deductible \$0
- Specialist [cost sharing] \$45
- Hospital (facility) [cost sharing] \$650
- Other [cost sharing] 0%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$675 |
| <u>Coinsurance</u> | \$80 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$755 |