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 ([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 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.mercycarehealthplans.com and view the Glossary at www.mercycarehealthplans.com You can call 1-800-895-2421 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 Self Only, $14,700 Self and Family, $14,700 Self Plus One	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventative	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 Self Only, $14,700 Self and Family, $14,700 Self Plus One	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 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, balance-billed charges, and health care this plan doesn't cover.	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.mercycarehealthplans.com or call 1-800-895-2421 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	$20/ visit	No covered	--none--
	Specialist visit	$40/ visit	No covered	--none--
	Preventive care/screening/ immunization	No charge	No covered	Full coverage if required by Federal law
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	No covered	--none--
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	No covered	Prior authorization is required for PET scans, and MRIs.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mercycarehealthplans.com	Generic drugs	$20/prescription	No covered	Limited to a 30 day supply, No generic available, you still pay the brand name copay
	Preferred brand drugs	$75/prescription	No covered	Limited to a 30 day supply, No generic available, you still pay the brand name copay
	Non-preferred brand drugs	$150/prescription	No covered	Limited to a 30 day supply, No generic available, you still pay the brand name copay
	Specialty drugs	$250/prescription	Not covered	Limited to a 30 day supply, No generic available, you still pay the brand name copay
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	Not covered	Prior authorization is required.
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	Prior authorization is required.
If you need immediate medical attention	Emergency room care	$150/ visit	$150/ visit	Co-pay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	--none--
	Urgent care	$40/visit	$40/visit	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not covered	Prior authorization 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)	
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	Prior authorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance after deductible	Not covered	Prior authorization is required.
	Inpatient services	10% coinsurance after deductible	Not covered	Prior authorization is required.
If you are pregnant	Office visits	No charge- Routine prenatal or first postpartum care visit; $40 per office visit for all postpartum care thereafter	Not covered	--none--
	Childbirth/delivery professional services	10% coinsurance after deductible	Not covered	Prior authorization is required.
	Childbirth/delivery facility services	10% coinsurance after deductible	Not covered	Prior authorization is required.
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	Not covered	Coverage is limited to 60 visits per contract year. Prior authorization is required.
	Rehabilitation services	10% coinsurance after deductible	Not covered	Coverage is limited to a combined 60 visits per condition (physical, occupational, and speech therapy, or habilitative services). Prior authorization is required.
	Habilitation services	10% coinsurance after deductible	Not covered	Coverage is limited to a combined 60 visits per condition (physical, occupational, and speech therapy, or habilitative services). Prior authorization is required.
	Skilled nursing care	10% coinsurance after deductible	Not covered	Up to 120 days of confinement per benefit year.
	Durable medical equipment	10% coinsurance after deductible	Not covered	Prior authorization is required.
	Hospice services	10% coinsurance after deductible	Not covered	Prior authorization 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 your child needs dental or eye care	Children's eye exam	No charge	Not covered	--none--
	Children's glasses	Not covered	Not covered	--none--
	Children's dental check-up	Not covered	Not covered	--none--

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (glasses)
- Routine foot care (except if related to medical diagnosis)
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care exams (adult)
- 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 800-895-2421 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 receive 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 plan's FEHB brochure. If you need assistance, you can contact Mercycare Health Plans at 1-800-895-2421.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 FEHB Plan brochure RI 73-866 at www.mercycarehealthplans.com.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 800-895-2421.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-895-2421.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-895-2421.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-895-2421.]

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	**$500**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**10%**
Other *[cost sharing]*	**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	**$12,775**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$120
Coinsurance	$1,240
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,920**

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

The plan's overall deductible	**$500**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**10%**
Other *[cost sharing]*	**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	**$7,582**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,835
Coinsurance	$186
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,576**

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

The plan's overall deductible	**$500**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**10%**
Other *[cost sharing]*	**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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$120
Coinsurance	$107
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$727**

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