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 (73-886) 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.uhcfeds.com and view the Glossary at www.uhcfeds.com. You can call 1-877-835-9861 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 /Self Only,$1,000 /Self Plus One, $1,000 /Self and Family in-network; $1,000 Self Only, $2,000 Self Plus One, $2,000 Self and Family out-of-network	See the Common Medical Events chart below for your costs and services this plan covers.
Are there services covered before you meet your deductible?	Yes	Preventive care visits (in-network) are covered 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?	Yes	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. There are per-occurrence deductibles in this plan for hospital based lab services, hospital based surgical services, hospital based diagnostic testing services. There are other specific deductibles.
What is the out-of-pocket limit for this plan?	$3,000 Self Only/ $6,000 Self Plus One or Self and Family in-network; $6,000 Self Only, $12,000 Self Plus One, $12,000 Self and Family out-of-network	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Chiropractic services; not covered services, premiums, charges that exceed day or dollar limit; balance billing charges	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.uhc.com or www.uhcfeds.com or call 1-877-835-9861 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 all charges if you use an out-of-network provider you may receive a bill from the 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 will pay some or all of the costs to see a specialist for covered services. She the chart on page 2 for how this plan pays different kinds of providers.

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	$25 copay/visit	50% coinsurance+	**+ = Out-of-Network (OON) - plus charges that exceed our plan allowance (this note applies to all OON benefits**
	Specialist visit	$50 copay/visit Premium designated (Tier 1) / $75 copay/visit Non-premium designated	50% coinsurance +	
	Preventive care/screening/ immunization	Nothing	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	Nothing at free-standing lab. 20% coinsurance hospital-based lab	Not covered out of network	
	Imaging (CT/PET scans, MRIs)	20% coinsurance at free-standing center or physician's office. 20% coinsurance plus per-occurrence deductible of $500 at hospital out-patient diagnostic center	Not covered out of network	Prior authorization required
	Tier 1 - up to 30-days at retail	$ 10/prescription	Not covered	
	Tier 2 - up to 30-days at retail	$ 35/prescription	Not covered	
	Tier 3 - up to 30-days at retail	$ 70/prescription	Not covered	

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)	
Prescription Drugs **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available at www.uhcfeds.com	Tier 4 - up to 30-days at retail	$ 120/prescription	Not covered	
Specialty Prescription Drugs	Tier 1 – Max. 30-day supply	$ 10/prescription	Not covered	Must be obtained from UHC Specialty Pharmacy
	Tier 2 – Max. 30-day supply	$150/prescription	Not covered	Must be obtained from UHC Specialty Pharmacy
	Tier 3 – Max. 30-day supply	$ 350/prescription	Not covered	Must be obtained from UHC Specialty Pharmacy
	Tier 4 - Max. 30-day supply	$ 500/prescription	Not covered	Must be obtained from UHC Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance free-standing ambulatory surgical center; 20% coinsurance plus $500 per-occurrence deductible at hospital based surgical center	50% coinsurance+ at free-standing surgical center; 50% coinsurance+ and per-occurrence deductible at hospital based surgical center	
	Physician/surgeon fees	20% coinsurance	50% coinsurance +	
If you need immediate medical attention	Emergency room care	$275 copay/visit	$275 copay/visit	Waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$75 copay/visit	50% coinsurance +	

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 a hospital stay	Facility fee (e.g., hospital room)	Tier 1 Premium-designated Hospital -20% coinsurance plus $500 per-occurrence deductible. Non-premium hospital-20% coinsurance plus $1,000 per-occurrence deductible	50% coinsurance + plus $1,000 per-occurrence deductible	
	Physician/surgeon fees	20% coinsurance	50% coinsurance +	
If you need mental health, behavioral health, or substance abuse services	Outpatient services – office visits	$25 copay per office visit Facility-based treatment 20% coinsurance	50% coinsurance +	Refer to FEHB brochure 73-886 for ABA benefits
	Office visits ABA therapy	$25 copay per office visit	50% coinsurance +	
	Inpatient services	Tier 1 Premium-designated Hospital -20% coinsurance plus $500 per-occurrence deductible. Non-premium hospital-20% coinsurance plus $1,000 per-occurrence deductible	50% coinsurance + plus $1,000 per-occurrence deductible	
If you are pregnant	Office visits	$50 copay/visit Premium designated (Tier 1) /- first visit $75 copay/visit Non-premium designated- first visit	50% coinsurance +	
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance +	
	Childbirth/delivery facility services	Tier 1 Premium-designated Hospital 20% coinsurance plus $500 per-occurrence deductible. Non-premium hospital-20% coinsurance plus $1,000 per-occurrence deductible	50% coinsurance + plus per occurrence deductible of $1,000	

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 help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance +	Must contain a medical component; limit 60 days /year
	Rehabilitation services	$25 copay/visit	50% coinsurance +	Most services and limits
	Habilitation services	$25 copay/visit	50% coinsurance +	Most services and limits
	Skilled nursing care	20% coinsurance	50% coinsurance +	In facility 60 days per year
	Durable medical equipment	20% coinsurance	Not covered out-of-network	Some prior auth required
	Hospice services	20% coinsurance	50% coinsurance +	
If your child needs dental or eye care	Children's eye exam	$0 copay	50% coinsurance +	Routine eye exam is preventive care
	Children's glasses	Not covered	Not Covered	See Non-FEHB benefits
	Children's dental check-up	Not covered	Not Covered	See Non-FEHB benefits

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.)

- Cosmetic procedures
- Dialysis services now must be in network to be covered
- Durable medical equipment must now be in network to be covered
- Dental care
- Laboratory, x-ray, diagnostic testing and radiology must be in network to be covered
- Infertility treatments
- Long-term care
- Non-emergency care when traveling outside of the US
- Private-duty nursing
- Routine foot care covered for diabetics only
- Services that exceed day limit
- Charges that exceed plan allowance

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)		
• Acupuncture • Bariatric surgery • Chiropractic care	• Hearing Aids – limits apply • Non-FEHB PPO dental – children and adults	• Real Appeal (Weight Loss) • Routine vision examinations for vision correction • Clinical programs that offer cost savings

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 877-835-9861 or visit www.opm.gov/healthcare-insurance/healthcare/. 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:.

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 877-835-9861.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-835-9861.]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 877-835-9861.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 877-835-9861.]

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]*	$50-$75
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$500
Copayments	$50
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$2,550**

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]*	$50-$75
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$500
Copayments	$395
Coinsurance	$200
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$1,095**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$500
Copayments	$525
Coinsurance	$75
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$1,100**

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