**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 (73-896) 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<br>$ 1,000/Self Plus One<br>$ 1,000/Self and Family | 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 | Primary Care visits, specialist visits, virtual visits, preventive care visits 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. Pharmacy Tier 3 and Tier 4 have a separate deductible of $250 Self Only and $500 Self Plus One or Self and Family. There are no other deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | $7,350 Self Only/ $14,700 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. |
| **What is not included in the out-of-pocket limit?** | Chiropractic services, not covered services, premiums, charges that exceed day or dollar limit | 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 as this plan has in-network benefits only. 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 to ensure that they are in-network for your plan. |
| **Do you need a referral to see a specialist?** | No | You can see the in-network 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 | $0 all ages/visit | Not Covered | Not subject to deductible |
| | Specialist visit | $60 copay/visit | Not Covered | Not subject to deductible |
| | Preventive care/screening/ Immunization | $0 copay for services billed as preventive | Not Covered | Not subject to deductible |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | Not Covered | |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not Covered | |
| **Prescription Drugs**<br>**If you need drugs to treat your illness or condition**<br>More information about prescription drug coverage is available at www.uhcfeds.com | Tier 1 - up to 30-days at retail | $ 5 copay/prescription | Not Covered | |
| | Tier 2 - up to 30-days at retail | $ 50 copay/prescription | Not Covered | |
| | Tier 3 - up to 30-days at retail | $ 100 copay*/prescription | Not Covered | Pharmacy deductible of $250 Self Only, $500 Self Plus One and Self and Family applies to Tier 3 and Tier 4 only |
| | Tier 4 - up to 30-days at retail | $ 150 copay*/prescription | Not Covered | Pharmacy deductible of $250 Self Only, $500 Self Plus One and Self and Family applies to Tier 3 and Tier 4 only |
| **Specialty Prescription Drugs** | Tier 1 – Max. 30-day supply | $ 5/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 |

| 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 ambulatory surgical center, 20% coinsurance plus $250 per occurrence deductible at hospital-based facility | Not Covered | |
| | Physician/surgeon fees | 20% coinsurance | Not Covered | |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | Not Covered | Waived if admitted |
| | Emergency medical transportation | 20% coinsurance | Not Covered | |
| | Urgent care | $50 copay/visit | Not Covered | Deductible does not apply |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not Covered | |
| | Physician/surgeon fees | 20% coinsurance | Not Covered | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services – office visits | No copay/visit | Not Covered | |
| | Applied Behavioral Analysis office visits | No copay/visit | Not Covered | Subject to medical necessity |
| | Outpatient hospital or other covered facility visits | 20% coinsurance | Not Covered | |
| | Inpatient services | 20% coinsurance | Not Covered | |
| **If you are pregnant** | Office visits | $60 specialist copay for 1st visit | Not Covered | |
| | Childbirth/delivery professional services | 20% coinsurance | Not Covered | |
| | Childbirth/delivery facility services | 20% coinsurance | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | Not Covered | Must contain a medical component; 60 visits per year |
| | Rehabilitation services | 20% coinsurance | Not Covered | |
| | Habilitation services | 20% coinsurance | Not Covered | Subject to medical necessity |
| | Skilled nursing care | 20% coinsurance | Not Covered | In facility 60 days per year |

| 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) | |
| | Durable medical equipment | 20% coinsurance | Not Covered | Some prior auth required |
| | Hospice services | 20% coinsurance | Not Covered | |
| **If your child needs dental or eye care** | Children's eye exam | $0 copay | Not Covered | 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
- Dental care adults
- Dental care children
- 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

**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 - $2,500 per ear limit every 3 years
- Non-FEHB PPO dental – children and adults
- Real Appeal (Weight Loss)
- Routine Eye care

**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]**

For more information about limitations and exceptions, see the FEHB Plan brochure 73-896 at www.uhcfeds.com.

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]*** **$60**
- **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 | $60 |
| Coinsurance | $2,500 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Peg would pay is** | **$3,600** |

### 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]*** **$60**
- **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 | $400 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Joe would pay is** | **$2,000** |

### 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 | $10 |
| Coinsurance | $626 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Mia would pay is** | **$1,136** |

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