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 (73-891) 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?	$2,000 /Self Only; $4,000 Self Plus One, $4,000/ Self and Family in-network; $4,000 Self Only, $8,000 Self Plus One, $8,000 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	See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.. These services must be in-network.
Are there other deductibles for specific services?	No	This plan does not have any deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,000 Self Only/ $12,000 Self Plus One or Self and Family in-network; $12,000 Self Only, $24,000 Self Plus One, $24,000 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, services that exceed stated dollar or day limits, balance billing fees for out-of-network 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.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 and 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 and x-ray). Check with your provider before you get services.

Do you need a referral to see a specialist?	No	You can see the in-network specialist you choose without a referral. You may need to obtain your own prior authorization for services from out-of-network providers when necessary

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	$15 copay	30% coinsurance +	+ = Out-of-Network (OON) -plus charges that exceed our plan allowance (this applies to all out-of-network visits
	Specialist visit	$30 copay/visit	30% coinsurance +	
	Preventive care/screening/ Immunization	$0 copay for services billed as preventive	Not Covered	Services must be billed as preventive
If you have a test	Diagnostic test (x-ray, blood work)	$50 per outpatient visit	Not Covered	In-network benefit only
	Imaging (CT/PET scans, MRIs)	$150 copay/visit	Not Covered	In-network benefit only
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 1 - up to 30-days at retail	$ 10/prescription	Not Covered	
	Tier 2 - up to 30-days at retail	$ 40/prescription	Not Covered	
	Tier 3 - up to 30-days at retail	$ 85/prescription	Not Covered	
	Tier 4 - up to 30-days at retail	$ 175/prescription	Not Covered	
Specialty Prescriptions	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

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)	
	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)	$250 copay/surgery	30% coinsurance +	
	Physician/surgeon fees	20% coinsurance	30% coinsurance +	
If you need immediate medical attention	Emergency room care	$275 copay/visit	30% coinsurance +	
	Emergency medical transportation	$500 copay for air ambulance $0 copay for ground ambulance	30% coinsurance +	
	Urgent care	$35 copay/visit	30% coinsurance +	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admission	30% coinsurance +	
	Physician/surgeon fees	20% coinsurance	30% coinsurance +	
If you need mental health, behavioral health, or substance abuse services	Outpatient services – office visits	$30 copay/visit	30% coinsurance +	
	Applied Behavioral Therapy	$30 copay/specialist visit	30% coinsurance +	See Section 5(a) Treatment therapies and 5(a) Habilitative/Rehabilitative services
	Facility-based treatment	$50 copayment per day	30% coinsurance *	Partial hospitalization, half-way house, intensive outpatient treatment, residential treatment
	Inpatient services	$500 copay per admission	30% coinsurance +	
If you are pregnant	Office visits	$30 specialist copay for 1st visit	30% coinsurance +	
	Childbirth/delivery professional services	Routine services included	30% coinsurance +	
	Childbirth/delivery facility services	$500 copay per admission	30% coinsurance +	
If you need help recovering or have other special health needs	Home health care	$30 copayment/visit	30% coinsurance +	Must contain a medical component;
	Rehabilitation services	$30 specialist copay/visit	30% coinsurance +	limits apply
	Habilitation services	$30 specialist copay/visit	30% coinsurance +	Subject to medical necessity
	Skilled nursing care	$0 copay if transferred from inpatient	30% coinsurance +	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	In-network coverage only
	Hospice services	20% coinsurance	30% coinsurance +	
If your child needs dental or eye care	Children's eye exam	$0 copay	30% coinsurance +	Routine eye exam is preventive care
	Children's glasses	Not covered	30% coinsurance +	
	Children's dental check-up	Not covered	30% coinsurance +	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
- Hearing Aids – adults
- Hearing Aids - children
- 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
- 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]

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** **$1,500**
- **Specialist *[cost sharing]*** **$30**
- **Hospital (facility) *[cost sharing]*** **$500**
- **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	$1,500
Copayments	$600
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$5,100**

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

- **The plan's overall deductible** **$2,500**
- **Specialist *[cost sharing]*** **$60**
- **Hospital (facility) *[cost sharing]*** **$500**
- **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	$1,500
Copayments	$660
Coinsurance	$200
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$2.360**

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

- **The plan's overall deductible** **$1,500**
- **Specialist *[cost sharing]*** **$60**
- **Hospital (facility) *[cost sharing]*** **$500**
- **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	$1,500
Copayments	$250
Coinsurance	$150
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$1,900**

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