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 RI 72-007 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.compassrosebenefits.com/brochure , and view the Glossary at https://www.healthcare.gov/sbc-glossary You can call 888-438-9135 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network providers $500 / Self Only $1,000 / Self Plus One $1,000 / Self and Family Out-of-network providers No coverage	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. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network: preventive care, professional services of physicians in a physician's office, urgent care, prescriptions and emergency services/accidents.	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?	$9,000 / Self Only $18,000 / Self Plus One or Self and Family for you or any covered family member combined; Pharmacy Network providers are included.	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-billing charges, healthcare this plan doesn't cover, expenses for dental care, and noncompliance penalties.	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. You must use in-network providers for your care to be eligible for benefits, except in certain circumstances, such as emergency care. See https://www.compassrosebenefits.com/uhc or call 888-438-9135 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	$10/visit for Primary Premium Care Physician; $35/visit for Primary Care Provider without premium designation; Deductible does not apply	Not Covered You pay 100%	None
	Specialist visit	$30/visit for Specialty Premium Care Physician; $70/visit for Specialist without premium designation; Deductible does not apply	Not Covered You pay 100%	None

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)	
	Preventive care/screening/ immunization	No Charge; Deductible does not apply	Not Covered You pay 100%	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible	Not Covered You pay 100%	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	Not Covered You pay 100%	Prior authorization required (maximum $500 penalty)
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at compassrosebenefits.com/formulary	Generic drugs	**Retail** - $5 **Mail order** - $10 Deductible does not apply	Not Covered You pay 100%	Price for retail pharmacy is for up to a 30-day supply (you can receive a 90-day supply of maintenance medications at Walgreens and CVS retail stores for the same cost as mail order); Price for mail order is for a 90-day supply
	Preferred brand drugs	**Retail** – 40% of the plan cost up to a max of $400 **Mail order** - 40% of the plan cost up to a max of $800 Deductible does not apply	Not Covered You pay 100%	
	Non-preferred brand drugs	100% coinsurance	Not Covered You pay 100%	
	Specialty drugs	**Generic** - 50% of the plan cost up to a max of $500 **Formulary** - 50% of the plan cost up to max of $1,500 **Non-Formulary**-100% coinsurance Deductible does not apply	Not Covered You pay 100%	Price is for up to a 30-day supply; Must be obtained through Optum Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	Not Covered You pay 100%	Prior authorization is required for surgical services (maximum $500 penalty).
	Physician/surgeon fees	30% coinsurance after deductible	Not Covered You pay 100%	

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 immediate medical attention	Emergency room care	$500/visit; Deductible does not apply	$500/visit; Deductible does not apply	Copayment is waived if admitted to the hospital
	Emergency medical transportation	30% coinsurance after deductible	30% coinsurance after deductible	None
	Urgent care	$50/visit; Deductible does not apply	Not Covered You pay 100%	Copayment is waived if admitted to the hospital
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	Not Covered You pay 100%	Prior authorization required (maximum $500 penalty)
	Physician/surgeon fees	30% coinsurance after deductible	Not Covered You pay 100%	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance after deductible	Not Covered You pay 100%	25-visit maximum per calendar year for residential treatment services and other outpatient services, including: partial hospitalization, half-way house, full day hospitalization or facility based intensive outpatient treatment. Prior authorization required for residential treatment services and partial hospitalization (maximum $500 penalty)
	Inpatient services	30% coinsurance after deductible	Not Covered You pay 100%	Prior authorization required (maximum $500 penalty)
If you are pregnant	Office visits	30% coinsurance after deductible	Not Covered You pay 100%	None
	Childbirth/delivery professional services	30% coinsurance after deductible	Not Covered You pay 100%	None

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)	
	Childbirth/delivery facility services	30% coinsurance after deductible	Not Covered You pay 100%	Prior authorization required if hospital stay goes beyond 48 hours for a vaginal delivery and 96 hours for a cesarean delivery or if newborn stays after mother's discharge (maximum $500 penalty). Non-routine maternity services may have applicable copayment/coinsurance applied.
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	Not Covered You pay 100%	25-visit maximum per calendar year; Prior authorization required after 12th visit (maximum $500 penalty)
	Rehabilitation services	30% coinsurance after deductible	Not Covered You pay 100%	25 total combined outpatient physical, occupational and speech therapy visits per calendar year; Prior authorization required after first 12 visits (maximum $500 penalty)
	Habilitation services	30% coinsurance after deductible	Not Covered You pay 100%	
	Skilled nursing care	Not Covered You pay 100%	Not Covered You pay 100%	None
	Durable medical equipment	30% coinsurance after deductible	Not Covered You pay 100%	Prior authorization is required for items costing $500 or more to rent or $1,500 or more to purchase (maximum $500 penalty)
	Hospice services	30% coinsurance after deductible	Not Covered You pay 100%	Prior authorization required (maximum $500 penalty)
If your child needs dental or eye care	Children's eye exam	No charge; Deductible does not apply	Not Covered You pay 100%	None
	Children's glasses	Charges in excess of $100 annual maximum	Charges in excess of $100 annual maximum	None
	Children's dental check-up	Charges in excess of $39, twice per year	Charges in excess of $39, twice per year	The Plan covers $39 twice a year for routine oral examinations, including x-rays, cleaning, diagnosis and preparation of a treatment plan. These expenses are not included in the out-of-pocket limit.

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 Surgery
- Custodial Care
- Hearing aids
- Long term care
- Private duty nursing
- Routine foot care

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

- Acupuncture for anesthesia and pain relief up to a maximum of 12 visits per calendar year
- Bariatric surgery when an Optum Bariatric Resource Services program provider is used
- Chiropractic care up to a maximum of 12 visits per calendar year
- Dental care (Adult) limited to $39 twice a year for routine oral examinations
- Infertility treatment up to $1,000 per calendar year. Three cycles of drugs and medical services related to artificial insemination and three cycles for in-vitro fertilization related drugs
- Non-emergency care when traveling outside the U.S. See www.compassrosebenefits.com/brochure
- Routine eye care (Adult) limited to $100 a year
- Weight loss programs limited to 4 nutritional counseling sessions per year

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 888-438-9135 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: 888-438-9135.

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 888-438-9135.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-438-9135.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 888-438-9135.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-438-9135.

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 *copayment*** **$30**
- **Hospital (facility) *copayment*** **$400**
- **Other *coinsurance*** **30%**

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	$3,600
What isn't covered	
Limits or exclusions	$15
The total Peg would pay is	**$4,165**

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 *copayment*** **$30**
- **Hospital (facility) *copayment*** **$400**
- **Other *coinsurance*** **30%**

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	$300
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

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

- **The plan's overall deductible** **$500**
- **Specialist *copayment*** **$30**
- **Hospital (facility) *copayment*** **$400**
- **Other *coinsurance*** **30%**

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	$500
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,550**

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