



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 71-028 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 <u>deductible</u> ?	<u>In-network providers</u> \$500 / Self Only \$1,000 / Self Plus One \$1,000 / Self and Family <u>Out-of-network providers</u> No coverage	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. <u>Copayments</u> and <u>coinsurance</u> amounts do not count toward your <u>deductible</u> , which generally starts over January 1. When a covered service/supply is subject to a <u>deductible</u> , only the <u>Plan</u> allowance for the service/supply counts toward the <u>deductible</u> . If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>In-network: preventive care</u> , professional services of physicians in a physician's office, urgent care, prescriptions.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$9,000 / Self Only \$18,000 / Self Plus One or Self and Family Pharmacy Network <u>providers</u> are included.	The <u>out-of-pocket limit</u> , or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, healthcare this <u>plan</u> doesn't cover, expenses for dental care,	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

	and noncompliance penalties.	
Will you pay less if you use a <u>network provider</u>?	Yes. You must use in-network <u>providers</u> 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 <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10/visit for Primary Premium Care Physician; \$35/visit for <u>Primary Care Provider</u> without premium designation; <u>Deductible</u> does not apply	Not Covered You pay 100%	None
	<u>Specialist</u> visit	\$30/visit for Specialty Premium Care Physician; \$70/visit for <u>Specialist</u> without premium designation; <u>Deductible</u> does not apply	Not Covered You pay 100%	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>Deductible</u> does not apply	Not Covered You pay 100%	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.

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 test	Diagnostic test (x-ray, blood work)	30% <u>coinsurance</u> after <u>deductible</u>	Not Covered You pay 100%	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u> after <u>deductible</u>	Not Covered You pay 100%	Prior authorization required (maximum \$500 penalty)
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at compassrosebenefits.com/formulary	Generic drugs	Retail - \$5 Mail order - \$10 <u>Deductible</u> 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 <u>plan</u> cost up to a max of \$400 Mail order - 40% of the <u>plan</u> cost up to a max of \$800 <u>Deductible</u> does not apply	Not Covered You pay 100%	
	Non-preferred brand drugs	100% <u>coinsurance</u>	Not Covered You pay 100%	
	<u>Specialty drugs</u>	Generic - 50% of the <u>plan</u> cost up to a max of \$500 Formulary - 50% of the <u>plan</u> cost up to max of \$1,500 Non-Formulary -100% <u>coinsurance</u> <u>Deductible</u> 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% <u>coinsurance</u> after <u>deductible</u>	Not Covered You pay 100%	Prior authorization is required for surgical services (maximum \$500 penalty)
	Physician/surgeon fees	30% <u>coinsurance</u> after <u>deductible</u>	Not Covered You pay 100%	
If you need immediate medical attention	<u>Emergency room care</u>	30% coinsurance; after <u>deductible</u>	30% coinsurance; after <u>deductible</u>	<u>Coinurance</u> is waived if admitted to the hospital

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)	
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Urgent care</u>	\$50/visit; <u>Deductible</u> does not apply	Not Covered You pay 100%	<u>Copayment</u> is waived if admitted to the hospital
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u> after <u>deductible</u>	Not Covered You pay 100%	Prior authorization required (maximum \$500 penalty)
	Physician/surgeon fees	30% <u>coinsurance</u> after <u>deductible</u>	Not Covered You pay 100%	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u> after <u>deductible</u>	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% <u>coinsurance</u> after <u>deductible</u>	Not Covered You pay 100%	Prior authorization required (maximum \$500 penalty)
If you are pregnant	Office visits	30% <u>coinsurance</u> after <u>deductible</u>	Not Covered You pay 100%	None
	Childbirth/delivery professional services	30% <u>coinsurance</u> after <u>deductible</u>	Not Covered You pay 100%	None
	Childbirth/delivery facility services	30% <u>coinsurance</u> after <u>deductible</u>	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

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)	
				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	<u>Home health care</u>	30% <u>coinsurance</u> after <u>deductible</u>	Not Covered You pay 100%	25-visit maximum per calendar year; Prior authorization required after 12 th visit (maximum \$500 penalty)
	<u>Rehabilitation services</u>	30% <u>coinsurance</u> after <u>deductible</u>	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)
	<u>Habilitation services</u>	30% <u>coinsurance</u> after <u>deductible</u>	Not Covered You pay 100%	
	<u>Skilled nursing care</u>	Not Covered You pay 100%	Not Covered You pay 100%	None
	<u>Durable medical equipment</u>	30% <u>coinsurance</u> after <u>deductible</u>	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)
	<u>Hospice services</u>	30% <u>coinsurance</u> after <u>deductible</u>	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; <u>Deductible</u> 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 <u>Plan</u> covers \$39 twice a year for routine oral examinations, including x-rays, cleaning, diagnosis and preparation of a treatment <u>plan</u> . These expenses are not included in the <u>out-of-pocket</u> 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.)

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| • Cosmetic Surgery | • Hearing aids | • Private duty nursing |
| • Custodial Care | • Long term care | • Routine foot care |

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

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| • Acupuncture for anesthesia and pain relief up to a maximum of 12 visits per calendar year | • Dental care (Adult) limited to \$39 twice a year for routine oral examinations | • Non-emergency care when traveling outside the U.S. See www.compassrosebenefits.com/brochure |
| • Bariatric surgery when an Optum Bariatric Resource Services program <u>provider</u> is used | • 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 | • Routine eye care (Adult) limited to \$100 a year |
| • Chiropractic care up to a maximum of 12 visits per calendar 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. Your plan documents provide information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact t: 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, kwijigo 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 <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$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 <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$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 <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$600
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,200