




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 73-026) 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.unionhealth.org, and view the Glossary at www.unionhealth.org. You can call 1-312 423-4200 extension 3285 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$ 0 /Self Only \$ 0 / Self Plus One \$ 0 /Self and Family	See the Common Medical Event chart below for your cost for services this <u>plan</u> covers.
Are there services covered before you meet your deductible ?	Yes, preventive care, hospital care inpatient and outpatient.	This <u>plan</u> covers some items and services even if you haven't yet met the deductible amount. See a list of covered preventive services at: https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductible for specific services?	Yes, \$ 100 /Self Only \$ 300 /Self Plus One \$ 300 /Self and Family: For orthopedic, prosthetic devices and durable medical equipment. There are no other deductibles	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this <u>plan</u> ?	\$ 7,350/Self Only \$ 14,700/Self Plus One \$ 14,700/Self and Family	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 limit</u> until the overall <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit ?	Premiums penalties for failure to obtain pre-authorization.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider ?	Yes. See www.unionhealth.org or call 1-312 423-4200 extension 3285 for a list of network providers .	This <u>plan</u> uses a provider network. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes	The <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the specialist.

 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/visit	Not covered	None
	<u>Specialist</u> visit	\$15/visit	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what you plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$15/visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$15/visit	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.unionhealth.org	Generic drugs	\$15/30 day supply \$40/90 day supply	Not covered	Covers up to a 30 day supply.
	Preferred brand drugs	\$45/30 day supply \$112.50/90 day supply	Not covered	Covers up to a 30 day supply.
	Non-preferred brand drugs	\$80/30 day supply \$200/90 day supply	Not covered	Covers up to a 30 day supply.
	<u>Specialty drugs</u>	20% coinsurance up to \$2,500 per member per year	Not covered	Covers up to a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	\$15/visit	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$125/visit	\$125 /visit	None
	<u>Emergency medical transportation</u>	Nothing	Nothing	Air ambulance excluded
	<u>Urgent care</u>	\$15/visit at a UHS office \$50/visit when directed \$125/visit when not directed	\$50/visit when directed \$125//visit when not directed	\$15/visit at a UHS office \$50/visit (when directed by UHS) to an <u>urgent care</u> center, \$125/visit at a hospital or (non-directed) <u>urgent care</u> center

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)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance misuse services	Outpatient services	\$15/visit	Not covered	None
	Inpatient services	\$15/visit	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	None
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	\$15/visit	Not covered	None
	<u>Rehabilitation services</u>	\$15/visit	Not covered	60 visit limit. Cardiac rehabilitation up to 30 sessions
	<u>Habilitation services</u>	\$15/visit	Not covered	60 visit limit.
	<u>Skilled nursing care</u>	No charge	Not covered	Up to 60 days per calendar year.
	<u>Durable medical equipment</u>	20% coinsurance after deductible.	Not covered	\$100 deductible per member \$300 maximum per family.
	<u>Hospice services</u>	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$15/visit	Not covered	None
	Children's glasses	Discount available	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental Services • Hearing Aids • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside of the U.S. • Private duty nursing • Services, drugs or supplies not medically necessary 	<ul style="list-style-type: none"> • Services, drugs or supplies you receive from a provider or facility barred from the FEHB Program • Services, drugs or supplies you receive without charge while in active military service

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

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|---|---|--|
| <ul style="list-style-type: none">• 24 Hour Emergency Line• Electronic Medical Records | <ul style="list-style-type: none">• Centers of Excellence for Transplants• Continuity of Care (low physician turnover) | <ul style="list-style-type: none">• Extended Hours• Not for Profit Organization |
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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 [contact number] or visit www.opm.gov/insure/health. 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 receive 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 plan's FEHB brochure. If you need assistance, you can contact: 312 423-4200 extension 3262.

Does this plan provide Minimum Essential Coverage? **Yes**, If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 [312-423-4200].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [312-423-4200].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [312-423-4200].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [312-423-4200].]

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 (**deductible**, **copayment** and **coinsurance**) and **coinsurance** 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 \$0
- **Specialist [cost sharing]** \$15
- Hospital (facility) **[cost sharing]** 0%
- Other **[cost sharing] ultrasound** \$15

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	
Diagnostic tests (ultrasound and lab work)	\$15
Deductibles	\$0
Copayments	\$160
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$160

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

- The **plan's** overall deductible \$0
- **Specialist [cost sharing]** \$15
- Hospital (facility) **[cost sharing]** 0%
- Other **[cost sharing]** \$15

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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1580
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1580

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

- The **plan's** overall deductible \$0
- **Specialist [cost sharing]** \$15
- Hospital (facility) **[cost sharing]** \$125
- Other **[cost sharing]** \$15

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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$200

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