Union Health Service: High Option **Coverage for: Self Only, Self Plus One or Self and Family | Plan Type: HMO**

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 RI73-026 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 http://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 the plan covers.
Are there services covered before you meet your deductible?	Yes, preventive care, hospital care inpatient and outpatient.	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?	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 deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$ 7,350/Self Only $ 14,700/Self Plus One $ 14,700/Self and Family	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 limit** until the overall **out-of-pocket limit** 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 out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.unionhealth.org or call 1-312 423-4200 ext. 3285 for a list of **network providers.**	This plan uses a provider network. 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services, but only if you have a referral 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
	Specialist visit	$30/visit 50% coinsurance for covered infertility services	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that are not 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)	$15/visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	$50/visit	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	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.
	Specialty drugs	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)	$50 copay per visit	Not covered	None
	Physician/surgeon fees	$30/visit	Not covered	None

If you need immediate medical attention	Emergency room care	$125/visit	$125 /visit	None
	Emergency medical transportation	Nothing	Nothing	Air ambulance excluded
	Urgent care	$15/visit at an 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 urgent care center, $125/visit at a hospital or (non-directed) urgent care center
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay for the first 4 days per admission	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15/visit	Not covered	None
	Inpatient services	$300 copay for the first 4 days per admission	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	$300 copay for the first 4 days per admission	Not covered	None
If you need help recovering or have other special health needs	Home health care	$15/visit	Not covered	None
	Rehabilitation services	$15/visit	Not covered	60 visit limit. Cardiac rehabilitation up to 30 sessions
	Habilitation services	$15/visit	Not covered	60 visit limit.
	Skilled nursing care	No charge	Not covered	Up to 60 days per calendar year.
	Durable medical equipment	20% coinsurance after deductible.	Not covered	$100 deductible per member $300 maximum per family.
	Hospice services	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 Plan Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any other excluded services.)

- Infertility coverage for in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), gamete intrafallopian tube transfer (GIFT), and zygote intrafallopian transfer (ZIFT)
- Acupuncture
- Cosmetic surgery
- Hearing Aids
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private duty nursing
- Dental Services
- Services, drugs or supplies not medically necessary
- Benefits received 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 is not a complete list. Please see your plan's FEHB brochure.)

- Infertility treatment (except IVF, ICSI, GIFT and ZIFT, see above section)
- Bariatric surgery
- Routine eye care
- Routine foot care
- Weight loss programs
- Non-emergency care when traveling outside the U.S.

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 (312) 423-4200. extension 3285, 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: UHS Member Services Department (312) 423-4200, extension 3285.

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, kwiijigo 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 (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** **$0**
- **Specialist (copayment)** **$30**
- **Hospital (facility) (*copay per day*)** **$300**
- **Other *ultrasound (copayment)*** **$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**

In this example, Peg would pay:

Cost Sharing	
Diagnostic tests (ultrasound & lab work)	$15
Deductibles	$0
Copayments	$570
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$585**

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 *(copayment)*** **$30**
- **Hospital (facility) (*copay per day*)** **$300**
- **Other *(copayment)*** **$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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,980
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1980**

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

- **The plan's overall deductible** **$0**
- **Specialist *(copayment)*** **$30**
- **Hospital (emergency room copayment)** **$125**
- **Other *(copayment)*** **$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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$230
Coinsurance	$
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$230**

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