This is only a summary. Please read the FEHB Plan 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. You can get the FEHB Plan brochure at www.compassrosebenefits.com or by calling 1-866-368-7227.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 350/self only PPO $ 700/self and family PPO	You must pay all the costs up to the **deductible** amount before this plan begins to pay for certain covered services you use. **Copayments** and **coinsurance** amounts do not count toward your **deductible**, which generally starts over January 1st. When a covered service or supply is subject to a **deductible**, only the Plan allowance for the service or supply counts toward the **deductible**. See the chart starting on page **2** for how much you pay for covered services after you meet the **deductible** and for which services are subject to the **deductible**.
Are there other deductibles for specific services?	No	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.
Is there an out–of–pocket limit on my expenses?	Yes. $4,000 PPO $7,000 non-PPO	The **out-of-pocket limit,** or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, chiropractic copayments	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page **2** describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of providers, see www.compassrosebenefits.com/**UHC** or call 1-888-438-9135.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. [We use the terms **preferred** or participating for **providers** in our **network**.] See the chart starting on page **2** for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page **5**. See this plan's FEHB brochure for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use United Healthcare **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit	30% coinsurance	Deductible does not apply for in-network
	Specialist visit	$25/visit	30% coinsurance	Deductible does not apply for in-network
	Other practitioner office visit	$20/chiropractor visit	30% coinsurance	Limited to 20 visits per person per calendar year
	Preventive care/screening/immunization	No charge	No charge	None
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Deductible applies
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Deductible applies
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com/pharmacy	Generic drugs retail	$5/ prescription	Not applicable	Only obtainable at a 30 day supply
	Preferred brand drugs retail	$35/ prescription	Not applicable	Only obtainable at a 30 day supply
	Non-preferred brand drugs retail	30% or $50, whichever is greater	Not applicable	Only obtainable at a 30 day supply
	Generic Drugs home delivery	$10/90 day supply	Not applicable	Only obtainable at a 90 day supply
	Preferred brand drugs home delivery	$70/90 day supply	Not applicable	Only obtainable at a 90 day supply
	Non-preferred brand drugs home delivery	30% or $100, whichever is greater	Not applicable	Only obtainable at a 90 day supply

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
	Preferred Specialty drugs	7% up to a maximum of $150 per 30 day supply	Not applicable	Must be obtained through home delivery
	Non-preferred Specialty drugs	10% up to a maximum of $300 per day supply	Not applicable	Must be obtained through home delivery
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Deductible applies
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Deductible does not apply for in-network
If you need immediate medical attention	Emergency room services	$100/per visit	$100/per visit	Copayment is waived if admitted to the hospital
	Emergency medical transportation	10% coinsurance	10% coinsurance	Deductible applies
	Urgent care	$50/per visit	30% coinsurance	Deductible does not apply for in-network
If you have a hospital stay	Facility fee (e.g., hospital room)	$200/per stay	$400/per stay and 30% of the covered charges	Precertification is required for hospital stays; failure to do so will result in a minimum $500 penalty
	Physician/surgeon fee	10% coinsurance	30% coinsurance	Deductible does not apply for in-network
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15/visit	30% coinsurance	Deductible does not apply for in-network
	Mental/Behavioral health inpatient services	$200/per stay	$400/per stay and 30% coinsurance	Precertification is required for hospital stays; failure to do so will result in a minimum $500 penalty
	Substance use disorder outpatient services	10% coinsurance	30% coinsurance	Deductible does not apply for in-network
	Substance use disorder inpatient services	$200/per stay	$400/per stay and 30% coinsurance	Precertification is required for hospital stays; failure to do so will result in a minimum $500 penalty
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
	Delivery and all inpatient services	$200/per stay facility charges; 10% coinsurance	$400/per stay facility charges; 30% coinsurance	You do not have to pre-certify your normal delivery, see www.compassrosebenefits.com for other circumstances. No deductible applies for out-of-network.
If you need help recovering or have other special health needs	Home health care part-time basis	Charges over $180/visit	30% coinsurance	All therapy services will count toward the 90 day therapy visit limitation per calendar year; Precertification is required; failure to do so will result in a minimum $500 penalty
	Home health care full-time basis	10% coinsurance	30% coinsurance	Limited to the same guidelines as part-time home health services listed above; Deductible applies
	Rehabilitation services	10% coinsurance	30% coinsurance	90 total combined outpatient, physical, speech, and occupational visits per calendar year; Deductible applies
	Habilitation services	10% coinsurance	30% coinsurance	Limited to the same guidelines as Rehabilitation guidelines listed above; Deductible applies
	Skilled nursing care	Charges in excess of 90 days	30% coinsurance; Charges in excess of 90 days	Precertification is required; failure to do so will result in a minimum $500 penalty
	Durable medical equipment	10% coinsurance	30% coinsurance	Deductible applies
	Hospice service	$200/per stay	$400/per stay and 30% coinsurance	Precertification is required; failure to do so will result in a minimum $500 penalty
If your child needs dental or eye care	Eye exam	No charge	No charge	Covered under Preventive Care Benefits
	Glasses	All charges	All charges	You pay all charges
	Dental check-up	Charges in excess of $39, twice per year	Charges in excess of $39, twice per year	Routine oral examinations including x-rays, cleaning, diagnosis and preparation of a treatment plan

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check this plan's FEHB brochure for other excluded services.)

- Acupuncture, except when used as an anesthetic for covered surgery
- Massage Therapy
- Cosmetic surgery
- Dental Care (Adult)
- Long-term care
- Routine eye care
- Routine foot care
- Therapy for developmental delay

Other Covered Services (This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic Care; limited to manipulation of the spine and extremities
- Hearing aids
- Infertility services; limited to $5,000 per live birth
- Non-emergency care when traveling outside the U.S
- Private duty nursing
- Weight loss programs; limited to 4 nutritional counseling services per year

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. An individual policy may also provide different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-866-368-7227 or visit www.opm.gov.insure/health.

Your Appeal 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: 1-888-438-9135.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **Coverage under this plan qualifies as minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-866-368-7227.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-368-7227.

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-368-7227.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-368-7227.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,900
- **Patient pays** $640

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$210
Coinsurance	$280
Limits or exclusions	$150
Total	**$640**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,560
- **Patient pays** $840

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$350
Copays	$200
Coinsurance	$210
Limits or exclusions	$80
Total	**$840**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.