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 (73-129) 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.uhcfeds.com, and view the Glossary at https://www.healthcare.gov/sbc-glossary. You can call 1-877-545-7378 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable	Not applicable
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?	$3,500 Self Only/ $7,000 Self Plus One or 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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for not obtaining any required prior-authorization, premiums, balance-billing charges, and health care this plan doesn't cover.	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 http://www.healthplanofnevada.com/Member/Doctor-or-Provider or call 1-877-545-7378 for a list of Plan 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?	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
		Plan Provider (You will pay the least)	Non-Plan 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 copay/visit	Not Covered	None
	Specialist visit	$25 copay/visit	Not Covered	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.
	Preventive care/screening/ immunization	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 your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay/visit	Not Covered	Member pays for cost of services if prior authorization is not obtained for certain services.
	Imaging (CT/PET scans, MRIs)	MRI/CT scan: $20 copay/service PET Scan: $200 copay/test	Not Covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www uhcfeds.com	Tier 1	$7 copay/prescription (retail) $14 copay/prescription (mail)	Not Covered	Covers up to a 30-day retail supply or up to a 90-day mail order supply. Member pays for cost of services if prior authorization or step therapy is not obtained.
	Tier 2	$35 copay/prescription (retail) $70 copay/prescription (mail)	Not Covered	
	Tier 3	$55 copay/prescription (retail) $110 copay/prescription	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most, plus you may be balance billed)	
		(mail)		
	Tier 4	$100 copay/prescription (retail) $200 copay/prescription (mail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay/admission	Not Covered	Member pays for cost of services if prior authorization is not obtained for elective hospital stays.
	Physician/surgeon fees	$25 copay/surgery	Not Covered	
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	
	Emergency medical transportation	Ground: $50 copay/trip Air: $250 copay/trip	Ground: $50 copay/trip Air: $250 copay/trip	
	Urgent care	$30 copay/visit	$30 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/admission	Not Covered	Member pays for cost of services if prior authorization is not obtained for elective hospital stays.
	Physician/surgeon fees	$25 copay/surgery	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/office visit and $50 copay/ facility visit	Not Covered	Member pays for cost of services if prior authorization is not obtained for some services.
	Inpatient services	$300 copay/admission	Not Covered	
If you are pregnant	Office visits	No charge	Not Covered	Routine prenatal care obtained from a Plan Provider is covered at no charge. Maternity care may include tests and services described elsewhere in the SBC (i.e. Lab).
	Childbirth/delivery professional services	Surgical: $25 copay	Not Covered	
	Childbirth/delivery facility services	$300 copay/admission	Not Covered	
If you need help recovering or have	Home health care	No charge	Not Covered	Member pays for cost of services if prior authorization is not obtained.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most, plus you may be balance billed)	
other special health needs	Rehabilitation services	$10 copay/visit	Not Covered	Coverage is limited to 60 days/visits per year. Member pays for cost of services if prior authorization is not obtained.
	Habilitation services	$10 copay/visit	Not Covered	Coverage is limited to 60 days/visits per year. Member pays for cost of services if prior authorization is not obtained.
	Skilled nursing care	$300 copay/admit	Not Covered	Coverage is limited to 100 days. Member pays for cost of services if prior authorization is not obtained.
	Durable medical equipment	No charge	Not Covered	Whichever DME copayment is less applies. For purchase or rental at HPN's option. Member pays for cost of services if prior authorization is not obtained.
	Hospice services	$300 copay/admission	Not Covered	Member pays for cost of services if prior authorization is not obtained.
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	Vision exams are limited to an annual eye refraction exam. Please refer to your plan documents for more information.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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.)

- Abortion (except for rape, incest, life at risk)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S
- Routine foot care
- Weight loss programs
- Private-duty nursing

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

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)

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 1-877-545-7378 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 request a brochure from your plan at www.uhcfeds.com, contact HPN's Member Services by calling 1-877-545-7378 or write to Health Plan of Nevada, P.O. Box 15645, Las Vegas, NV 89114-5645.

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 1-877-545-7378

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-545-7378

[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-877-545-7378

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-545-7378

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	**$0.00**
Specialist copayment	**$25.00**
Hospital (facility) copayment	**$300.00**
Other copayment	**$50.00**

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	$0.00
Copayments	$800.00
Coinsurance	$100.00
What isn't covered	
Limits or exclusions	$80.00
The total Peg would pay is	**$980.00**

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

The plan's overall deductible	**$0.00**
Specialist copayment	**$25.00**
Hospital (facility) copayment	**$50.00**
Other copayment	**$10.00**

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	$0.00
Copayments	$500.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$40.00
The total Joe would pay is	**$540.00**

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

The plan's overall deductible	**$0.00**
Specialist copayment	**$25.00**
Hospital (facility) copayment	**$50.00**
Other copayment	**$10.00**

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	$0.00
Copayments	$300.00
Coinsurance	$100.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$400.00**

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