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 (73-797) 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.upmchealthplan.com/FEHB and view the Glossary at www.cciio.cms.gov. You can call 1-877-648-9641 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$650/Self Only $1,300/ Self Plus One $1,300/Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. If you have other family member on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Deductible does not apply to Preventive Care.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,000/Self Only $10,000/ Self Plus One $10,000/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?	Premium, balance-billed charges (unless balanced billing is prohibited), 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 www.upmchealthplan.com/FEHB	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

	or call 1-877-648-9641 for a list of network providers.	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?	No.	You can see the specialist you choose without a referral.

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 copayment/visit	All Charges	If a facility fee is charged for an office visit then there is no additional cost to the member.
	Specialist visit	$40 copayment/visit	All Charges	
	Preventive care/screening/ immunization	No Cost	All Charges	
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	All Charges	A facility fee applies to services if the services are performed in an ambulatory surgical center, outpatient department of a hospital, or an outpatient clinic owned by a hospital.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	All Charges	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.upmchealthplan.com/FEHB	Generic drugs	$20 copayment/prescription (Retail), $40 copayment/prescription (Mail order)	All Charges	30-day supply for Retail and 90-day supply for Mail order.
	Preferred brand drugs	$50 copayment/prescription (Retail), $100 copayment/prescription (Mail order)	All Charges	30-day supply for Retail and 90-day supply for Mail order.
	Non-preferred brand drugs	$100 copayment/prescription (Retail), $200 copayment/prescription (Mail order)	All Charges	30-day supply for Retail and 90-day supply for Mail order.
	Specialty drugs	50% coinsurance/ prescription	All Charges	Maximum of $250/prescription.

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)	
				30-day supply for Specialty. Mail order not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	All Charges	A facility fee applies to services if the services are performed in an ambulatory surgical center, outpatient department of a hospital, or an outpatient clinic owned by a hospital.
	Physician/surgeon fees	15% coinsurance	All Charges	None
If you need immediate medical attention	Emergency room care	$150 copayment/visit	$150 copayment/visit	Copayment waived if admitted.
	Emergency medical transportation	15% coinsurance	15% coinsurance	None
	Urgent care	$75 copayment/visit	All Charges	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	All Charges	Preauthorization may be required. If preauthorization is not obtained, benefits could be denied.
	Physician/surgeon fees	15% coinsurance	All Charges	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copayment/visit	All Charges	If a facility fee is charged for an office visit then there is no additional cost to the member.
	Inpatient services	15% coinsurance	All Charges	Preauthorization may be required. If preauthorization is not obtained, benefits could be denied.
If you are pregnant	Office visits	$15 copayment/visit	All Charges	None
	Childbirth/delivery professional services	No Cost	All Charges	Depending on the type of services, other cost shares may apply. Maternity care may include tests and services described elsewhere in the SBC (*i.e.,* ultrasound). Office visit cost share applies to first visit only.
	Childbirth/delivery facility services	No Cost	All Charges	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	All Charges	None
	Rehabilitation services	$15 copayment/visit	All Charges	Limited to the greater of 60 consecutive days of coverage or 25 visits per outpatient condition, per calendar year. Cardiac rehabilitation following a heart transplant,

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)	
				bypass surgery, or a myocardial infarction is provided for up to 12 weeks of sessions.
	Habilitation services	$15 copayment/visit	All Charges	See limit for Rehabilitation services.
	Skilled nursing care	15% coinsurance	All Charges	Limit of 100 days per Benefit Period. Preauthorization may be required. If preauthorization is not obtained, benefits could be denied.
	Durable medical equipment	15% coinsurance	All Charges	None
	Hospice services	15% coinsurance	All Charges	None
If your child needs dental or eye care	Children's eye exam	No Cost	All Charges	Once every 24 months for adults, once every 12 months for children under age 19
	Children's glasses	Not Covered	All Charges	None
	Children's dental check-up	Not Covered	All Charges	None

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.)

- Cosmetic surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-excepted abortion services
- Weight loss programs
- Dental care

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

- Acupuncture only covered for specific diagnosis
- Bariatric surgery subject to medical review
- Chiropractic care covered with limitations
- Exception abortion services
- Hearing aids covered with limitations
- Infertility treatments covered with limitations
- Private-duty nursing subject to medical review
- Routine eye care
- Routine foot care only covered for specific diagnoses

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 1-877-648-9641 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: OPM at (202) 606-1800.

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 1-877-648-9641.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-648-9641.
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-877-648-9641.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-648-9641.

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	**$650**
Specialist	**$40**
Hospital (facility)	**0%**
Other	**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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

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

The plan's overall deductible	**$650**
Specialist	**$40**
Hospital (facility)	**15%**
Other	**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	**$7,640**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$110
Copayments	$3,170
Coinsurance	$20
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,360**

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

The plan's overall deductible	**$650**
Specialist	**$40**
Hospital (facility)	**15%**
Other	**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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$650
Copayments	$630
Coinsurance	$130
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,410**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.upmchealthplan.com.

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

Nondiscrimination Notice

UPMC Health Plan[1] complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UPMC Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UPMC Health Plan:

• Provides free aids and services to people with disabilities so that they can communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

• Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact the Member Services phone number listed on the back of your member ID card.

If you believe that UPMC Health Plan has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a complaint with:

Complaints and Grievances
PO Box 2939
Pittsburgh, PA 15230-2939

Phone: 1-844-755-5611 (TTY: 1-800-361-2629)
Fax: 1-412-454-5964
Email: HealthPlanCompliance@upmc.edu

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019. TTY/TDD users should call 1-800-537-7697.

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

[1]UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC *for You* Inc., and/or UPMC Benefit Management Services Inc.

Translation Services
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-420-9589 (TTY: 1-800-361-2629).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-420-9589
（TTY：1-800-361-2629）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số
1-866-420-9589 (TTY: 1-800-361-2629).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-420-9589 (телетайп: 1-800-361-2629).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-420-9589
(TTY: 1-800-361-2629).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-866-420-9589 (TTY: 1-800-361-2629)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-420-9589 (TTY: 1-800-361-2629).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-420-9589
(رقم هاتف الصم والبكم: 1-800-361-2629).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-420-9589 (ATS : 1-800-361-2629).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-420-9589 (TTY: 1-800-361-2629).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો ન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-420-9589 (TTY: 1-800-361-2629).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-420-9589 (TTY: 1-800-361-2629).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele
1-866-420-9589 (TTY: 1-800-361-2629).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-866-420-9589 (TTY: 1-800-361-2629)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-420-9589 (TTY: 1-800-361-2629).