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 73-007 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. 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.Emblemhealth.com/federal and view the Glossary at www.emblemhealth.com/federal You can call 1-800-624-2414 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	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.
Are there services covered before you meet your deductible?	Yes.	This plan covers most eligible, medical services without a deductible.
Are there other deductibles for specific services?	Yes. $100 annual deductible for durable medical equipment (DME)	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?	$6,850 for Self Only or $13,700 for 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.
What is not included in the out-of-pocket limit?	Premiums, out of network charges and healthcare 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.Emblemhealth.com/federal or call 800-624-2414 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay all charges 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?	No	This plan does not require referrals for specialists.

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	$50 copay / $10 copay dependent children/ visit	Not covered	None
	Specialist visit	$50 copay $10 copay dependent children/ visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay / per test	Not covered	Two copayments per date of service
	Imaging (CT/PET scans, MRIs)	$50 copay / per test	Not covered	Two copayments per date of service
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.emblemhealth.com	Generic drugs	Retail: $15 copay / Mail: $40 copay	Not covered	Retail: 30 day supply Mail: 90 day supply
	Preferred brand drugs	Retail: $50 copay/ Mail:$125 copay	Not covered	Retail: 30 day supply Mail: 90 day supply
	Non-preferred brand drugs	Retail: $100 copay / Mail: $170 copay	Not covered	Retail: 30 day supply Mail: 90 day supply
	Specialty drugs	25% coinsurance	Not covered	Up to a maximum of $200 per prescription
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$200 copay / visit	Any difference between the plan's fee schedule and the billed amount	None
	Emergency medical transportation	All charges in excess of $100	All charges in excess of $100	All charges in excess of $100
	Urgent care	$75 copay / visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 per day to max of $1000 per inpatient stay	Not covered	Prior approval may be required
	Physician/surgeon fees	No charge	Not covered	None

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 need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	Prior approval may be required
	Inpatient services	$500 per day to max of $1000 per inpatient st	Not covered	Prior approval may be required
If you are pregnant	Office visits	$50 initial copay – nothing for all prenatal and postnatal care	Not covered	Copay required for 1st prenatal visit only
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	$500 per day to max of $1000 per inpatient stay	Not covered	Limited to 48 hours for vaginal delivery and 96 hours for caesarean delivery
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	$50 copay / visit	Not covered	Out-patient coverage limited 60 visits per calendar year. Prior approval required
	Habilitation services	$50 copay / visit	Not covered	Out-patient coverage limited 60 visits per calendar year. Prior approval required
	Skilled nursing care	No charge	Not covered	Limited to 30 days per calendar year. Prior approval required
	Durable medical equipment	20% of the plans fee schedule	Not covered	$100 annual deductible per person
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	One per calendar year
	Children's glasses	No charge	Not covered	Frames every 24 months from a select group of frames. Lenses every year.
	Children's dental check-up	No charge	Not covered	Two routine exams per year.

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	• Non-emergency care when traveling outside of the U.S.	• Long term care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)		
• Bariatric surgery • Chiropractic	• Routine foot care • Acupuncture	• Hearing aids

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 1-800-624-2414 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: 1-800-624-2414.

Does this plan provide Minimum Essential Coverage? Yes

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 1-800-624-2414
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-2414
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-800-624-2414
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-2414

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	**$ 50**
Hospital (facility)	**$500**
Other	**$100**

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
Copayments	$1500
Coinsurance	$ 0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1500**

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	**$ 50**
Hospital (facility)	**$500**
Other	**$100**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$550
Coinsurance	$ 75
What isn't covered	
Limits or exclusions	$ 0
The total Joe would pay is	**$725**

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

The plan's overall deductible	**$ 0**
Specialist	**$ 50**
Hospital (facility)	**$500**
Other	**$100**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$350
Coinsurance	$ 20
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$470**

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