




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 (73-001) 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](http://www.emblemhealth.com/federal), and view the Glossary at [www.emblemhealth.com/federal](http://www.emblemhealth.com/federal). You can call 1-877-447-8255- to request a copy of either document.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <u>deductible</u>?</b></p>	<p>\$ 0 Self Only \$ 0/Self Plus One \$ 0/Self and Family</p>	<p>Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> 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 members on the policy, the overall family deductible must be met before the plan begins to pay.</p>
<p><b>Are there services covered before you meet your <u>deductible</u>?</b></p>	<p>Yes. Preventive and diagnostic services, inpatient admission and outpatient services, urgent care and emergency care services.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. "For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/..</a></p>
<p><b>Are there other <u>deductibles</u> for specific services?</b></p>	<p>Yes. \$100 brand name prescription drugs. \$50 durable medical equipment \$50 orthopedic and prosthetic devices</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>
<p><b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b></p>	<p>\$6,850 for Self Only or \$13,700 for Self Plus One or Self and Family</p>	<p>The <u>out-of-pocket limit</u>, 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.</p>
<p><b>What is not included in the <u>out-of-pocket limit</u>?</b></p>	<p>Premiums, coverage for out of network services and healthcare services not covered by this plan.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p><b>Will you pay less if you use a <u>network provider</u>?</b></p>	<p>Yes. See <a href="http://www.emblemhealth.com/federal">www.emblemhealth.com/federal</a></p>	<p>This <u>plan</u> uses a provider <u>network</u>. You will pay less if you use a provider in the plan's <u>network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (balance</p>



	or call 1-800-447-8255 for a list of <u>network providers</u> .	billing). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> 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)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 copay per visit	Not covered	None
	<u>Specialist</u> visit	\$50 copay per visit	Not covered	Referral required.
	<u>Preventive care/screening/immunization</u>	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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not Covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.emblemhealth.com/federal.com">www.emblemhealth.com/federal.com</a>	Generic drugs	Retail: \$25 copay per script Mail: \$37.50 copay per script	Not Covered	None
	Preferred brand drugs	Retail: \$50 copay per script Mail: \$75 copay per script	Not Covered	\$100 annual deductible on brand name drugs
	Non-preferred brand drugs	Retail: \$100 copay per script	Not covered	\$100 annual deductible on brand name drugs
	<u>Specialty drugs</u>	Retail: \$200 copay per script	Not covered	None. If the drug is less than the copay, you pay the lesser amount for 30 day Retail.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 copay per visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
	Emergency room care	\$250 copay per visit	\$250 copay per visit	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 immediate medical attention	<u>Emergency medical transportation</u>	No charge	Not covered	None
	<u>Urgent care</u>	\$30 copay per visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 copay 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	\$30 copay per visit	Not covered	Prior approval may be required.
	Inpatient services	\$100 copay per admission	Not covered	Prior approval may be required.
If you are pregnant	Office visits	No charge	Not covered	None
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	\$100 copay per admission	Not covered	Limited to 48 hours for natural delivery and 96 hours for Caesarean delivery unless medically necessary.
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	None
	<u>Rehabilitation services</u>	Inpatient: No charge Outpatient: \$50 copay per visit	Not covered	Outpatient coverage limited to 60 visits per condition per year. Prior approval required for outpatient services.
	<u>Habilitation services</u>	Inpatient: No charge Outpatient: \$50 copay per visit	Not covered	Outpatient coverage limited to 60 visits per condition per year. Prior approval required for outpatient services.
	<u>Skilled nursing care</u>	No charge	Not covered	Prior approval required. Limited to 90 days.
	<u>Durable medical equipment</u>	No charge	Not covered	Prior approval required. \$50 deductible applies.
	<u>Hospice services</u>	No charge	Not covered	Limited to 210 days.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	None
	Children's glasses	Not covered	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)	
	Children's dental check-up	No charge	Not covered	Limited to one examination (comprehensive or periodic), one cleaning, and one topical fluoride every six months.

### 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 <u>excluded services</u> .)			
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>Long term care</li> <li>Non-emergency care when traveling outside of the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private duty nursing</li> <li>Weight loss programs</li> </ul>	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)			
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Chiropractic care</li> <li>Dental care for adults</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care for adults</li> <li>Routine foot care</li> </ul>	

**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 1-877-447-8255 or visit [www.opm.gov/insure/health](http://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](http://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: HIP Customer Service: 1-877-447-8255  
 Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).  
 NYS Department of financial Services: <https://www.dfs.ny.gov>

### 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 1-877-447-8255

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-447-8255

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-447-8255

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-447-8255

————— *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 copay \$30
- Hospital (facility) copay \$100
- Other \$0

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$
Copayments	\$130
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Peg would pay is</b>	<b>\$130</b>

**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 copay \$50
- Hospital (facility) copay \$100
- Other \$0

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$
Copayments	\$150
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Joe would pay is</b>	<b>\$150</b>

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

- The plan's overall deductible \$0
- Specialist [cost sharing] \$50
- Hospital (facility) copay \$100
- Other \$0

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$
Copayments	\$150
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Mia would pay is</b>	<b>\$150</b>