
 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 73-001 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 1-800-447-8255 to request a copy of either document.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$ 2,500/Self Only \$ 5,000/ Self Plus One \$ 5,000/Self and Family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> 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.
<b>Are there services covered before you meet your deductible?</b>	Yes.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
<b>Are there other deductibles for specific services?</b>	Yes. \$300 for brand and non-preferred brand name prescription drugs	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$7,350 for Self Only or \$14,700 for Self Plus One or Self and Family	The <a href="#">out-of-pocket limit</a> , or catastrophic maximum, is the most you could pay in a year for covered services.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Premiums, coverage for out of network services and healthcare services not covered by this plan	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a provider in the plan's <a href="#">network</a> .
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> 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 / visit	Not covered	None
	<u>Specialist</u> visit	\$75 copay / visit	Not covered	Deductible applies. Referral required
	<u>Preventive care/screening/Immunization</u>	No charge	Not covered	None
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	\$75 copay/ visit	Not covered	Deductible applies
	Imaging (CT/PET scans, MRIs)	\$75 copay / visit	Not covered	Deductible applies
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.[insert].com">www.[insert].com</a>	Generic drugs	Retail: \$25 / 30 day supply	Not covered	None
	Preferred brand drugs	Retail: \$50 / 30 day supply	Not covered	\$300 annual deductible on preferred brand drugs
	Non-preferred brand drugs	Retail: \$100 /30 day supply	Not covered	\$300 annual deductible on Non-preferred brand drugs
	<u>Specialty drugs</u>	\$200 per script	Not covered	None
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 copay	Not covered	Deductible applies.
	Physician/surgeon fees	No charge	Not covered	None
<b>If you need immediate medical attention</b>	Emergency room care	\$250 copay / visit	\$250 copay / visit	None
	<u>Emergency medical transportation</u>	No charge	Not covered	None
	<u>Urgent care</u>	\$75 copay / visit	Not covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 copay / visit	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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 / visit	Not covered	Prior approval may be required
	Inpatient services	\$250 / visit	Not covered	Prior approval may be required
<b>If you are pregnant</b>	Office visits	\$30	Not covered	Copay required for 1 <sup>st</sup> visit only
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	\$150 / visit	Not covered	Limited to 48 hours for natural delivery and 96 hours for caesarean delivery
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	Not covered	None
	<u>Rehabilitation services</u>	In-patient: No charge Outpatient: \$75 copay / visit	Not covered	Deductible applies. Out-patient coverage limited to two months per condition. Prior approval required
	<u>Habilitation services</u>	In-patient: No charge Outpatient: \$75 copay / visit	Not covered	Deductible applies. Out-patient coverage limited to two months per condition. Prior approval required
	<u>Skilled nursing care</u>	No charge	Not covered	Prior approval required
	<u>Durable medical equipment</u>	No charge	Not covered	Prior approval required
	<u>Hospice services</u>	No charge	Not covered	Limited to 210 days
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Not covered	None
	Children's glasses	\$45 copay	Not covered	Every 24 months
	Children's dental check-up	No charge	Not covered	Limited to one examination (comprehensive or periodic) every six months, one cleaning every six months 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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care for adults
- Long term care
- Non-emergency care when traveling outside of the U.S.
- Routine foot 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
- Weight loss programs
- Chiropractic care
- Private duty nursing
- Hearing aids
- Routine eye care

**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 [contact number] 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: [insert applicable contact information from instructions].

#### 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 1-800-447-8255

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-447-8255

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-447-8255

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-447-8255

————— *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 <u>deductible</u>	\$2,500	0
■ <u>Specialist</u>	75	
■ Hospital (facility)	250	
■ 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*)

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

<i>Cost Sharing</i>	
Deductibles	0
Copayments	500
Coinsurance	0
<i>What isn't covered</i>	
Limits or exclusions	0
<b>The total Peg would pay is</b>	<b>\$500</b>

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

■ The plan's overall <u>deductible</u>	\$2,500	0
■ <u>Specialist</u>	75	
■ Hospital (facility)	250	
■ 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	300
Coinsurance	0
<i>What isn't covered</i>	
Limits or exclusions	0
<b>The total Joe would pay is</b>	<b>\$2,500</b>

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

■ The plan's overall <u>deductible</u>	\$2,500
■ <u>Specialist</u>	75
■ Hospital (facility)	250
■ 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	450
Coinsurance	0
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Mia would pay is</b>	<b>\$1,900</b>