



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 73-007 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](http://www.emblemhealth.com/federal), and view the Glossary at [www.emblemhealth.com/federal](http://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 <a href="#">deductible</a> ?	\$ <u>  0  </u> /Self Only \$ <u>  0  </u> /Self Plus One \$ <u>  0  </u> /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.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Preventive and diagnostic services, inpatient admission and outpatient services, urgent care and emergency care services.	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. "For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$100 annual deductible for durable medical equipment	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.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$8,150 for Self Only or \$16,300 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. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out of pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.emblemhealth.com/federal">www.emblemhealth.com/federal</a> or call 1-800-447-8255 for a list of <a href="#">network providers</a> .	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> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services. This <a href="#">plan</a> does not require a <a href="#">referral</a> before you see the <a href="#">specialist</a> .





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 provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$50 copay per visit/ \$10 copay per visit for dependent children	Not covered	None
	<u>Specialist</u> visit	\$50 copay per visit/ \$10 copay per visit for dependent children	Not covered	None
	<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)	\$50 copay per visit	Not covered	No more than two copayments per date of service.
	Imaging (CT/PET scans, MRIs)	\$50 copay per visit	Not covered	No more than two copayments per date of service.
<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.[insert].com">www.[insert].com</a>	Generic drugs	Retail: \$20 per script Mail: \$40 per script	Not covered	Retail: 30 day supply Mail: 90 day supply
	Preferred brand drugs	Retail: \$50 per script Mail: \$125 per script	Not covered	Retail: 30 day supply Mail: 90 day supply
	Non-preferred brand drugs	Retail: \$100 per script Mail: \$170 per script	Not covered	Retail: 30 day supply Mail: 90 day supply
	<u>Specialty drugs</u>	25% coinsurance	Not covered	Up to a maximum of \$200 per prescription
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 copay	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$200 copay per visit	Any difference between the plan's fee schedule and the billed amount	None
	<u>Emergency medical transportation</u>	No charge	Not covered	None
	<u>Urgent care</u>	\$30 copay per visit	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 have a hospital stay</b>	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
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge	Not covered	Prior approval may be required.
	Inpatient services	\$500 per day to max of \$1000 per inpatient stay	Not covered	Prior approval may be required.
<b>If you are pregnant</b>	Office visits	\$50 initial copay – nothing for all prenatal and postnatal care.	Not covered	Copay required for 1 <sup>st</sup> 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 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>	\$50 copay per visit	Not covered	Outpatient coverage limited to 60 visits per condition. Prior approval required for outpatient services.
	<u>Habilitation services</u>	\$50 copay per visit	Not covered	Outpatient coverage limited to 60 visits per condition. Prior approval required for outpatient services.
	<u>Skilled nursing care</u>	No charge	Not covered	Prior approval required. Limited to 30 days per calendar year.
	<u>Durable medical equipment</u>	20% of the plan's fee schedule	Not covered	\$100 annual deductible per person
	<u>Hospice services</u>	No charge	Not covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Not covered	One per calendar year
	Children's glasses	Not covered	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 FEHB Plan brochure for more information and a list of any other excluded services.)

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

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

- Bariatric surgery
- Routine foot care
- Routine eye care
- Chiropractic care
- Dental care for adults

**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 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 FEHB Plan brochure. If you need assistance, you can contact: GHI Customer Service: 1-800-624-2414

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

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 [1-800-624-2414].

[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, kwijigo 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 copay \$50
- Hospital (facility) copay \$1000
- 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>	
<u>Deductibles</u>	\$
<u>Copayments</u>	\$1,050
<u>Coinsurance</u>	\$
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Peg would pay is</b>	<b>\$1,050</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 \$1000
- 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>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$
<u>Copayments</u>	\$1050
<u>Coinsurance</u>	\$
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Joe would pay is</b>	<b>\$1050</b>

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

- The plan's overall deductible \$0
- Specialist copay \$50
- Hospital (facility) copay \$500
- 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>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$
<u>Copayments</u>	\$550
<u>Coinsurance</u>	\$
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Mia would pay is</b>	<b>\$550</b>