This is only a summary. Before you select a health plan in the Federal Employees Health Benefits (FEHB) Program, 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. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.emblemhealth.com or by calling 1-800-624-2414.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 0	See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible** and for which services are subject to the calendar year deductible.
Are there other deductibles for specific services?	Yes $100 annual deductible for 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.
Is there an out–of–pocket limit on my expenses?	Yes $6,350 Self $12,700 Self and Family	The **out-of-pocket limit,** or **catastrophic maximum,** is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, non essential services and prescription drugs	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes www.emblemhealth.com	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. [We use the term **preferred**, or participating for **providers** in our **network**.] See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See this plan's Federal brochure for additional information about **excluded services**.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay /visit	50% of the Plan's fee schedule	---none---
	Specialist visit	$20 copay /visit	50% of the Plan's fee schedule	---none---
	Other practitioner office visit	$20 copay /visit	50% of the Plan's fee schedule	---none---
	Preventive care/screening/immunization	$0	50% of the Plan's fee schedule	---none---
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay /visit	50% of the Plan's fee schedule	---none---
	Imaging (CT/PET scans, MRIs)	$20 copay /visit	50% of the Plan's fee schedule	---none---

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.emblemhealth.com	Generic drugs	$20 copay Retail/$40 copay Mail	All charges	---none---
	Preferred brand drugs	$45 copay Retail/$90 copay Mail	All charges	---none---
	Non-preferred brand drugs	$85 copay Retail/$125 Copay Mail	All charges	---none---
	Specialty drugs	25% coinsurance	All charges	$3,000 Out of Pocket Maximum for Specialty Drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay	All charges	Prior Approval Needed
	Physician/surgeon fees	$20 copay	All charges	Prior Approval Needed
If you need immediate medical attention	Emergency room services	$150 copay per ER visit	Any difference from our fee schedule and the billed amount	---none---
	Emergency medical transportation	All Charges in excess of $100	All charges in excess of $100	---none---
	Urgent care	$20 copay / visit	Any difference from our fee schedule and the billed amount	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 a day for max of $450 per inpatient admission	Same as above	Prior Approval Needed
	Physician/surgeon fee	$0	All charges	Prior Approval Needed

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$0	50% of the Plan's fee schedule	---none---
	Mental/Behavioral health inpatient services	$0	50% of the Plan's fee schedule	---none---
	Substance use disorder outpatient services	$0	50% of the Plan's fee schedule	---none---
	Substance use disorder inpatient services	$0	50% of the Plan's fee schedule	---none
If you are pregnant	Prenatal and postnatal care	After initial $20 copay, nothing for all prenatal and postnatal care	50% of the Plan's fee schedule	Routine sonograms to determine fetal age, sex or size is not covered.
	Delivery and all inpatient services	$150 a day for max of $450 per inpatient admission	50% of the Plan's fee schedule	48 Hours for natural delivery and 96 Hours for caesarean delivery. Prior Approval Needed.
If you need help recovering or have other special health needs	Home health care	$0	All charges	Prior Approval Needed
	Rehabilitation services	$20 copay /visit	50% of the Plan's fee schedule	60 Visits Per Condition
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	$0	All charges	Prior Approval Needed
	Durable medical equipment	20% of the Plan's fee schedule	All charges	$100 Annual Deductible per person
	Hospice service	$0	All charges	Limited to 210 Days
If your child needs dental or eye care	Eye exam	$0	Any difference from our fee schedule and the billed amount	One Per Calendar Year
	Glasses	$0	Same as above	One frame every two years, lenses one pair per year
	Dental check-up	$0	All charges in excess of $10.00	Two routine exams per calendar year

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic Surgery	• Long Term Care	• Non-emergency care when traveling outside the U.S.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric Surgery	• Chiropractic Care	• Hearing Aids
• Infertility Treatment	• Routine Foot Care	• Acupuncture

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy with the plan, and to receive temporary continuation of coverage (TCC). Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. An individual policy under the plan may also have different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your HR office/retirement system, your plan at 1-800-624-2414 or visit www.opm.gov.insure/health.

Your 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 appeals rights please see Section 3. (How you get care), and Section 8 (The disputed claims process) in your FEHB plan brochure at www.opm.gov/fehbbrochures or by requesting a brochure from your plan at GHI Customer, 441 Ninth Avenue, New York 10001.

Minimum Essential Coverage (MEC):

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement.

Minimum Value Standard:

The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

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 page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $ 7,440
- **Patient pays** $ 480

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$120
Coinsurance	$210
Limits or exclusions	$150
Total	**$480**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $ 4,525
- **Patient pays** $ 875

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$725
Coinsurance	$100
Limits or exclusions	$50
Total	**$875**

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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