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, and view the Glossary at www.emblemhealth.com/federal. You can call 1-877-447-8255 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. Preventive and diagnostic services, inpatient admission and outpatient services, urgent care and emergency care services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. "For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $100 brand name prescription drugs $50 durable medical equipment $50 orthopedic and prosthetic devices	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. 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.
What is not included in the out-of-pocket limit?	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 out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.emblemhealth.com/federal or call 1-800-447-8255 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 the most 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?	Yes.	This plan will pay some or all of the costs to see a specialist 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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit	Not covered	None
	Specialist visit	$50 copay per visit	Not covered	Referral required
	Preventive care/screening/ immunization	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.emblemhealth.com/federal	Generic formulary	Retail: $25 copay per script Mail: $37.50 copay per script	Not covered	None
	Brand name formulary	Retail: $50 copay per script Mail: $75 copay per script	Not covered	$100 annual deductible on brand drugs
	Non-formulary brand drugs	Retail: $100 copay per script	Not covered	$100 annual deductible on brand drugs
	Specialty drugs	Retail: $200 copay per script	Not covered	None. If the drug costs less than the copay, you pay the lesser amount for 30 day Retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay per visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$250 copay per visit	$250 copay per visit	None
	Emergency medical transportation	No charge	Not covered	None
	Urgent care	$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

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)	
	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	No charge	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	Home health care	No charge	Not covered	None
	Rehabilitation services	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.
	Habilitation services	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.
	Skilled nursing care	No charge	Not covered	Prior approval required. Limited to 90 days
	Durable medical equipment	No charge	Not covered	Prior approval required. $50 deductible applies
	Hospice services	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
	Children's dental check-up	No charge	Not covered	Limited to one examination (comprehensive or periodic), one cleaning, and one topical flouride every six months.

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.)

- Acupuncture
- Cosmetic surgery
- Long term care
- Non-emergency care when traveling outside of the U.S
- Private duty nursing
- Weight loss programs

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

- Bariatric surgery
- Chiropractic Care
- Dental care for adults
- Hearing aids
- Infertility treatment
- Routine eye care
- Routine foot 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 1-800-447-8255 or visit http://www.opm.gov/healthcare-insurance/healthcare/. 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 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:
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.
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 1-877-447-8255
[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, kwiijigo 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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$
Copayments	$130
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$130**

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$
Copayments	$150
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$150**

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*	**$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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$
Copayments	$150
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$150**

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