
 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 73-168) 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.healthalliance.org](http://www.healthalliance.org), and view the Glossary at [www.healthalliance.org](http://www.healthalliance.org). You can call 1-800-851-3379 to request a copy of either document.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$1,000 / Self Only \$2,000 / Self Plus One \$2,000 / Self and Family	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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Office Visits, Emergency Room, Emergency Medical Transportation, Urgent Care, Prescription Drugs, Routine Prenatal Care, Rehabilitation Services and Preventive Services.	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> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	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.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$7,350 / per person \$14,700 / self plus one \$14,700 / self and family	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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Health Care this plan does not cover and Premiums	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.healthalliance.org">www.healthalliance.org</a> or call 1-800-851-3379 for a list of <u>network providers</u> .	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 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 provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 co-pay/visit	Not Covered	—————none—————
	<u>Specialist</u> visit	\$60 co-pay/visit	Not Covered	—————none—————
	<u>Preventive care/screening/immunization</u>	No charge	Not Covered	One preventative visit and/or well women visit per plan year.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	25% co-insurance	Not Covered	—————none—————
	Imaging (CT/PET scans, MRIs)	25% co-insurance	Not Covered	Pre-authorization is required.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.healthalliance.org">www.healthalliance.org</a> .	Preferred generic and preventive care drugs	\$0 co-pay /prescription	Not Covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order)
	Non-Preferred generic drugs	\$10 co-pay /prescription	Not Covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order)
	Preferred brand name drugs.	\$40 co-pay /prescription	Not Covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order)
	<u>Non-Preferred brand name drugs</u>	\$140 co-pay /prescription	Not Covered	Pre-authorization is required.
	<u>Preferred specialty drugs</u>	\$200 co-pay /prescription	Not Covered	Pre-authorization is required.
	<u>Non-Preferred specialty drugs</u>	50% co-insurance	Not Covered	Pre-authorization is required.

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 outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% co-insurance	Not Covered	Preauthorization may be required for certain procedures. Contact Customer Service for detailed information.
	Physician/surgeon fees	25% co-insurance	Not Covered	—————none—————
<b>If you need immediate medical attention</b>	Emergency room care	\$300 co-pay/visit	\$300 co-pay/visit	—————none—————
	<u>Emergency medical transportation</u>	\$100 co-pay	\$100 co-pay	—————none—————
	<u>Urgent care</u>	\$50 co-pay/visit	\$50 co-pay/visit	—————none—————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	25% co-insurance	Not Covered	—————none—————
	Physician/surgeon fees	25% co-insurance	Not Covered	—————none—————
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 co-pay/visit	Not Covered	—————none—————
	Inpatient services	25% co-insurance	Not Covered	—————none—————
<b>If you are pregnant</b>	Office visits	\$60 copay for routine prenatal care	Not Covered	—————none—————
	Childbirth/delivery professional services	25% co-insurance	Not Covered	—————none—————
	Childbirth/delivery facility services	25% co-insurance	Not Covered	—————none—————
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	25% co-insurance	Not Covered	Preauthorization is required. 50 visits per condition per calendar year maximum.
	<u>Rehabilitation services</u>	\$60 co-pay/visit	Not Covered	60 visits per condition per calendar year maximum.
	<u>Habilitation services</u>	\$60 co-pay/visit	Not Covered	60 visits per condition per calendar year maximum.
	<u>Skilled nursing care</u>	25% co-insurance	Not Covered	75 days per condition per calendar year maximum.
	<u>Durable medical equipment</u>	25% co-insurance	Not Covered	Preauthorization may be required for certain medical equipment. Contact Customer Service for detailed information.
	<u>Hospice services</u>	25% co-insurance	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)	
If your child needs dental or eye care	Children's eye exam	\$60 co-pay/visit	Not Covered	_____none_____
	Children's glasses	Not Covered	Not Covered	_____none_____
	Children's dental check-up	Not Covered	Not Covered	_____none_____

**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
- Long-term care
- Private-duty nursing
- Weight loss programs
- Cosmetic surgery
- Most coverage provided outside the United States. See [www.healthalliance.org](http://www.healthalliance.org)
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.

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

- Bariatric surgery
- Infertility treatment (limited)
- Chiropractic care
- Routine eye care (Adult)
- Hearing aids
- 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 1-800-851-3379 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: Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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 1-800-851-3379.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-851-3379.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-851-3379.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-851-3379.

—————*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 \$1,000
- Specialist \$60 co-pay/visit
- Hospital (facility) 25% coinsurance
- Other 10% coinsurance

**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	\$1,000
Copayments	\$30
Coinsurance	\$2,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,990</b>

**Managing Joe's type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,000
- Specialist \$60 co-pay/visit
- Hospital (facility) 25% coinsurance
- Other 10% coinsurance

**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	\$1,000
Copayments	\$1,100
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,240</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,000
- Specialist \$60 co-pay/visit
- Hospital (facility) 25% coinsurance
- Other 25% coinsurance

**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	\$600
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>





**Vietnamese:**

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Health Alliance Medical Plans quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-866-247-3296.

**Italian:**

Se tu o qualcuno che stai aiutando avete domande su Health Alliance Medical Plans, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-866-247-3296.

**Hindi:**

यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Health Alliance Medical Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िुभाषण से बात करने के लिए 1-866-247-3296 पर कॉि करें।

**French:**

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Health Alliance Medical Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un

interprète, appelez 1-866-247-3296.

**Greek:**

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Health Alliance Medical Plans, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-866-247-3296.

**German:**

Falls Sie oder jemand, dem Sie helfen, Fragen zum Health Alliance Medical Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-866-247-3296.