Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

EmblemHealth : EmblemHealth PPO **Coverage for:** Individual/Family **Plan Type:** PPO

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. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-624-2414. 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 view the Glossary at www.emblemhealth.com or call 1-800-624-2414 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0 in network providers, $1,000 Individual / $3,000 Family out of network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	In network services are not subject to a deductible. All out of network services, except emergency care, are subject to a deductible.	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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in network providers $7,150 Individual / $14,300 Family.	The out-of-pocket limit 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, penalties, balanced-bill charges, and health care this plan doesn't cover.	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. For a list of in network providers visit www.EmblemHealth.com or call 1-877-842-3625	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 the services.**
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Adult visit / No charge Dependent child visit	After deductible is met, 30% coinsurance	-----None-----
	Specialist visit	$25 Adult visit / No charge Dependent child visit	After deductible is met, 30% coinsurance	-----None-----
	Preventive care/screening/ immunization	No charge	After deductible is met, 30% coinsurance	-----None-----
If you have a test	Diagnostic test (x-ray, blood work)	$25 Adult visit / No charge Dependent child visit	After deductible is met, 30% coinsurance	Radiology services, e.g. X-ray, are covered under the Imaging benefit and Imaging cost-share applies. Radiology services require pre-certification.
	Imaging (CT/PET scans, MRIs)	$25 Adult visit / No charge Dependent child visit	After deductible is met, 30% coinsurance	Pre-certification required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.EmblemHealth.com.	Generic drugs (Tier 1)	Not covered	Not covered	
	Preferred brand drugs (Tier 2)	Not covered	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 co-pay/visits	After deductible is met, 30% coinsurance	Pre-certification required
	Physician/surgeon fees	No charge	After deductible is met, 30% coinsurance	-----None-----
If you need immediate medical attention	Emergency room care	$150 co-pay	$150 co-pay	Applies to facility charge, waived if admitted.
	Emergency medical transportation	Out-of-Network Benefit Only	Covered at 100% of Usual and Customary charge	-----None-----
	Urgent care	$50 Adult visit / No charge Dependent child visit	After deductible is met, 30% coinsurance	-----None-----

* For more information about limitations and exceptions, see the plan or policy document at **www.emblemhealth.com/sbc.**

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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 co-pay per admission	After deductible is met, 30% coinsurance	Pre-certification required
	Physician/surgeon fee	No charge	After deductible is met, 30% coinsurance	-----None-----
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$25 Adult visit / No charge Dependent child visit	After deductible is met, 30% coinsurance	Up to 20 family visits for substance abuse services
	Inpatient services	$250 co-pay per admission	After deductible is met, 30% coinsurance	Pre-certification required
If you are pregnant	Office visits	No charge	After deductible is met, 30% coinsurance	-----None-----
	Childbirth/delivery professional services	No charge	After deductible is met, 30% coinsurance	-----None-----
	Childbirth/delivery facility services	$250 co-pay per admission	After deductible is met, 30% coinsurance	-----None-----
If you need help recovering or have other special health needs	Home health care	No charge	After deductible is met, 30% coinsurance	200 visits per calendar year. Pre-certification required.
	Rehabilitation services	Inpatient: $250 co-pay per admission Outpatient: $25 Adult visit / No charge Dependent child visit	After deductible is met, 30% coinsurance	Inpatient: 30 days per calendar year. Outpatient: 30 visits per calendar year for Physical Therapy and 10 visits per calendar year for Speech Therapy.
	Habilitation services	Inpatient: $250 co-pay per admission Outpatient: $25 Adult visit / No charge Dependent child visit	After deductible is met, 30% coinsurance	
	Skilled nursing care	No charge	After deductible is met, 30% coinsurance	60 days per calendar year. Pre-certification required.
	Durable medical equipment	No charge	Not covered	Pre-certification required when amount is greater than $2,000
	Hospice services	No charge	Not covered	210 days per lifetime. Pre-certification 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)	
If your child needs dental or eye care	Children's eye exam	$0 co-pay	Not covered	One eye exam covered every 12 months through participating EyeMed/ CPS providers
	Children's glasses	$130 frame allowance. Standard single, bifocal or trifocal lenses: $0 co-pay. Contact lenses available in lieu of eyeglasses	Not covered	Available through participating EyeMed/ CPS providers: Frames covered every 12 months, lenses covered every 12 months
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Most coverage provided outside the United States. See www.emblemhealth.com
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Infertility treatment (Prior Approval required)
- Routine eye care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: New York State Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov/, U.S. Department of Health and Human Services at 1-877-267-2323 x1565 or www.cciio.cms.gov, U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/contactEBSA/consumerassistance.html or www.dol.gov/ebsa/healthreform. Other options may be available to you, too, including buying individual or SHOP insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596 or NY State of Health Marketplace at 1-855-355-5777 or www.nystateofhealth.ny.gov.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your right, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

EmblemHealth **By Phone:** Please call the number on your ID card. **In writing:** EmblemHealth Grievance and Appeals Department P.O. Box 2801 New York, NY 10116-2807 Website: www.emblemhealth.com	**For All Coverage Types** **New York State Department of Financial Services** **By Phone**: 1-800-342-3736 **In writing**: New York State Department of Financial Services Consumer Assistance Unit One Commerce Plaza Albany, NY 12257 Website: www.dfs.ny.gov

* For more information about limitations and exceptions, see the plan or policy document at **www.emblemhealth.com/sbc.**

For HMO Coverage	Consumer Assistance Program
New York State Department of Health **By Phone:** 1-800-206-8125 **In writing:** New York State Department of Health Office of Health Insurance Programs Bureau of Consumer Services – Complaint Unit Corning Tower – OCP Room 1607 Albany, NY 12237 Email: managedcarecomplaint@health.ny.gov Website: www.health.ny.gov	**New York State Consumer Assistance Program** **By Phone:** 1-888-614-5400 **In writing:** Community Health Advocates 633 Third Avenue, 10th Floor New York, NY 10017 Email: cha@cssny.org Website: www.communityhealthadvocates.org **For Group Coverage:** **U.S. Department of Labor** **Employee Benefits Security Administration** at 1-866-444-EBSA (3272) Website: www.dol.gov/ebsa/healthreform

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:

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.

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 (cost sharing)	$25
Hospital (facility) cost sharing	$250
Other cost sharing	$96

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 the example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$750
Coinsurance	$0
What isn't covered	
Limits or exclusions	$96
The total Peg would pay is	$846

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 (cost sharing)	$25
Hospital (facility) cost sharing	$250
Other cost sharing	$4,313

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 the example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$820
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,313
The total Joe would pay is	$5,133

Mia's Simple Fracture

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

The plan's overall deductible	$0
Specialist (cost sharing)	$25
Hospital (facility) cost sharing	$150
Other cost sharing	$162

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 the example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$763
Coinsurance	$0
What isn't covered	
Limits or exclusions	$162
The total Mia would pay is	$925

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

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ATTENTION: Language assistance services, free of charge, are available to you. Call **1-877-411-3625** (TTY/TDD: **711**).

Español (Spanish)
ATENCIÓN: Usted tiene a su disposición, gratis, servicios de ayuda para idiomas. Llame al **1-877-411-3625** (TTY/TDD: **711**).

中文 (Chinese)
注意：我們免費提供相關的語言協助服務。請致電 **1-877-411-3625** (TTY/TDD: **711**)。

Русский (Russian)
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика. Звоните по тел. **1-877-411-3625** (служба текстового телефона TTY/TDD: **711**).

Kreyòl Ayisyen (Haitian Creole)
ATANSYON: Gen sèvis èd nan lang gratis ki disponib pou ou. Rele nimewo **1-877-411-3625** (TTY/TDD: **711**).

한국어 (Korean)
주의: 귀하에게 언어 지원 서비스가 무료로 제공됩니다. **1-877-411-3625**(TTY/TDD: **711**)번으로 전화하십시오.

Italiano (Italian)
ATTENZIONE: sono disponibili servizi gratuiti di assistenza linguistica. Chiami il numero **1-877-411-3625** (TTY/TDD: **711**).

אידיש (Yiddish)
אכטונג: שפראך הילף סערוויסעס, אהן קיין פרייז, זיינען דא צו באקומען פאר אייך. רופט **1-877-411-3625** (TTY/TDD: **711**).

বাংলা (Bengali)
মনোযোগ দিন: ভাষা সহায়তা পরিষেবাগুলি আপনার জন্য বিনামূল্যে উপলব্ধ আছে। **1-877-411-3625** (TTY/TDD: **711**) নম্বরে ফোন করুন।

Polski (Polish)
UWAGA: dostępna jest bezpłatna pomoc językowa. Prosimy zadzwonić pod numer **1-877-411-3625** (TTY/TDD: **711**).

العربية (Arabic)
يرجى الانتباه: تتوفر لك خدمات المساعدة اللغوية مجانا، اتصل على الرقم **1-877-411-3625** أو (TTY/TDD: **711**).

Français (French)
ATTENTION : une assistance d'interprétation gratuite est à votre disposition. Veuillez composer le **1-877-411-3625** (TTY/TDD : **711**).

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اردو (Urdu)
وجہ دیں: آپ کے لیے زبان سے متعلق اعانت کی خدمات، مفت دستیاب ہیں۔ **1-877- 411-3625** (TTY/TDD: **711**) پر کال کریں۔

Tagalog (Tagalog)
NANANAWAGAN NG PANSIN: Mayroon kang magagamit na mga serbisyo para sa tulong sa wika nang walang bayad. Tawagan ang **1-877-411-3625** (TTY/TDD: **711**).

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ: Διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε το **1-877-411-3625** (για άτομα με προβλήματα ακοής (TTY/TDD): **711**).

Shqip (Albanian)
VINI RE: Shërbime ndihmore për gjuhën, falas, janë në dispozicionin tuaj. Telefononi në **1-877-411-3625** (TTY/TDD: **711**).

NOTICE OF NONDISCRIMINATION POLICY

EmblemHealth complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. EmblemHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

EmblemHealth:

- Provides free aids and services to people with disabilities to help
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call member services at **1-877-411-3625** (TTY/TDD: **711**).

If you believe that EmblemHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with EmblemHealth Grievance and Appeals Department, PO Box 2844, New York, NY 10116, or call member services at **1-877-411-3625**. (Dial **711** for TTY/TDD services.) You can file a grievance in person, by mail or by phone. If you need help filing a grievance, EmblemHealth's Grievance and Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at **U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201**; **1-800-368-1019**, (dial **1-800-537-7697** for TTY services).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.