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

**EmblemHealth : GHI HMO**

**Coverage for:** Individual/Family

**Plan Type:** HMO

---

**Coverage Period:** 07/01/2022 - 06/30/2023

---

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 | See the Common Medical Events chart below for your costs for services this plan covers.

**Are there services covered before you meet your deductible?**

In network medical and hospital services are not subject to a deductible. This plan covers some items and services even if you haven’t yet met the deductible. 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/](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?**

Not applicable

This plan does not have an out-of-pocket limit on your expenses.

**What is not included in the out-of-pocket limit?**

Not applicable

This plan does not have an out-of-pocket limit on your expenses.

**Will you pay less if you use a network provider?**

Yes. See www.EmblemHealth.com or call 1-800-447-8255 for a list of participating 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, written approval is required to see a specialist.

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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>*Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 co-pay visit</td>
<td>-----None-----</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$15 co-pay visit</td>
<td>-----None-----</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Applies to Well Child Visits; Adult Annual Physical Exams; Well Woman Exams; Bone Density Testing.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>-----None-----</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$15 co-pay visit</td>
<td>----None-----</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs (Tier 1)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.EmblemHealth.com">www.EmblemHealth.com</a></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>Preauthorization required</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>-----None-----</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$35 co-pay visit</td>
<td>Applies to facility charge, waived if admitted.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>-----None-----</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$35 co-pay visit</td>
<td>Applies to facility charge.</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>Preauthorization required</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>-----None-----</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>*Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Outpatient services $15 co-pay visit</td>
<td>Not covered</td>
<td>Unlimited visits. For Substance Abuse care, up to 20 visits per calendar year may be used for family counseling.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services No charge</td>
<td>Not covered</td>
<td>Preauthorization required. However, Preauthorization is not required for emergency admissions.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits No charge</td>
<td>Not covered</td>
<td>-----None-----</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services No charge</td>
<td>Not covered</td>
<td>-----None-----</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services  No charge</td>
<td>Not covered</td>
<td>Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Preauthorization required</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care No charge</td>
<td>Not covered</td>
<td>40 visits per calendar year. Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services Inpatient: No charge Outpatient: $15 co-pay visit</td>
<td>Not covered Inpatient: 60 days per calendar year combined therapies. Preauthorization required.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services Inpatient: No charge Outpatient: $15 co-pay visit</td>
<td>Not covered Outpatient: 60 visits per calendar year combined therapies. Preauthorization required.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care No charge</td>
<td>Not covered</td>
<td>120 days per calendar year. Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment 20% coinsurance</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Hospice services No charge</td>
<td>Not covered</td>
<td>210 days per lifetime. Preauthorization required.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam $15 co-pay</td>
<td>Not covered</td>
<td>Refractive eye exam</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up $5 co-pay/visit</td>
<td>Not covered</td>
<td>One oral exam every six months</td>
</tr>
</tbody>
</table>
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 eye care
- 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
- Private-duty nursing

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.cfsa.cms.gov, U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebbsa/contactEBSA/consumerassistance.html or www.dol.gov/ebbsa/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.nyshop.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 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
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

Consumer Assistance Program
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
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:
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijgo holne’ 1-800-624-2414

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Plan's overall deductible</th>
<th>Specialist (cost sharing)</th>
<th>Hospital (facility) cost sharing</th>
<th>Other cost sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$0</td>
<td>$15</td>
<td>$0</td>
<td>$96</td>
</tr>
</tbody>
</table>

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**: $12,800

**In the example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
<td>$300</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $96
- The total Peg would pay is: $396

### Managing Joe’s type 2 diabetes
- **(a year of routine in-network care of a well-controlled condition)**

<table>
<thead>
<tr>
<th>Service</th>
<th>Plan’s overall deductible</th>
<th>Specialist (cost sharing)</th>
<th>Hospital (facility) cost sharing</th>
<th>Other cost sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$0</td>
<td>$15</td>
<td>$0</td>
<td>$55</td>
</tr>
</tbody>
</table>

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**: $7,400

**In the example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
<td>$780</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $55
- The total Joe would pay is: $835

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Plan’s overall deductible</th>
<th>Specialist (cost sharing)</th>
<th>Hospital (facility) cost sharing</th>
<th>Other cost sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$0</td>
<td>$15</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

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**: $1,900

**In the example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Co-insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
<td>$120</td>
<td>$7</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0
- The total Mia would pay is: $127

The plan would be responsible for the other costs of these EXAMPLE covered services.
Getting Help in a Language Other than English

ATTENTION: This is an important document. If you need help to understand it, please call the telephone number marked “customer service” on the back of your member ID card [TTY/TDD: 711]. We can give you an interpreter for free in the language you speak.

Español (Spanish)
ATENCIÓN: Este es un documento importante. Si necesita ayuda para entenderlo, llame al número telefónico marcado “customer service” que se encuentra en el dorso de su tarjeta de identificación de miembro [TTY/TDD: 711]. Le podemos proporcionar un intérprete que habla su idioma sin ningún costo.

中文 (Traditional Chinese)
注意：这是重要的文件。如果您需要协助来瞭解文件內容，请致電您會員卡背面標記為“customer service”的電話號碼[TTY/TDD：711]。我們可以為您免費提供您所使用語言的翻譯人員。

Русский (Russian)
ВНИМАНИЕ! Это важный документ. Если у Вас возникли трудности с пониманием этого документа и Вам необходима помощь, позвоните по телефону отдела обслуживания клиентов (customer service), указанному на обратной стороне Вашей идентификационной карточки [служба текстового телефона (TTY/TDD): 711]. Мы можем бесплатно предоставить Вам переводчика, который говорит на Вашем языке.

Kreyòl Ayisyen (Haitian Creole)
ATANSYON: Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo ki make “customer service” nan do kat ID manm ou [TTY/TDD: 711]. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

한국어 (Korean)
주: 이것은 중요한 문서입니다. 이 문서를 이해하는 데 도움이 필요하시면 회원 ID 카드의 뒷면에 “customer service” 라고 표시된 전화번호[TTY/TDD: 711]로 연락해 주십시오. 저희는 귀하가 사용하는 언어에 대해 무료 통역사를 제공할 수 있습니다.

Italiano (Italian)
ATTENZIONE. Questo è un documento importante. Per qualsiasi chiarimento telefoni all “customer service” al numero stampato sul retro della Sua tessera (per i non utenti: 711). Possiamo mettere a disposizione gratis un interprete nella Sua lingua.

עִדִית (Yiddish)
מולאָנָה: זאָ וווען אָה בָּ יען זיך נאַגאָן. אַיזאָ אייר דראָפֶר רילקָה טאָ פאַראָגאָן, ייטן רופֶה טאבֶס טעגַע פֶּ timevalפפֶנ גַעְרְפֶנ דערעפפ "customer service" אַויע אַייר קארטלי [TTY/TDD: 711].
NOTICE OF NONDISCRIMINATION POLICY

EmblemHealth complies with applicable 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 communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the telephone number marked “customer service” on the back of your member ID card. 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 the telephone number marked “customer service” on the back of your member ID card. (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.