



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, \$200 Individual / \$500 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.	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 for durable medical equipment.	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 ?	For in network providers \$4,550 Individual / \$9,100 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. See www.EmblemHealth.com or call 1-877-842-3625 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). The amount that the plan pays is not related to usual and customary rates or to what the provider may charge but is set at a fixed amount based on GHI's 1983 reimbursement rates. Most of the reimbursement rates have not increased since that time, and will likely be less (and in many instances substantially less) than the provider's charge. Using an out-of-network provider , therefore, may result in a substantial out-of-pocket expense for you. 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 ?	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	Preferred: \$0 co-pay per visit Non-Preferred: \$15 co-pay per visit	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	-----None-----
	Specialist visit	Preferred: \$0 co-pay per visit Non-Preferred: \$30 co-pay per visit	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	Lower co-pay applies when a Preferred Provider refers
	Preventive care/screening/immunization	No charge	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	-----None-----
If you have a test	Diagnostic test (x-ray, blood work)	Preferred: \$0 co-pay per visit Non-Preferred: \$20 co-pay per visit	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	-----None-----
	Imaging (CT/PET scans, MRIs)	Preferred: \$50 co-pay per visit Non-Preferred: \$100 co-pay per visit	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	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 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)	Retail-30 day supply-2 fills; 20% coinsurance with min charge of \$5 or actual cost if less	Not covered	Retail-90 day supply; \$12.50 co-pay. Prescriptions will not be filled at retail after 2 fills.
	Preferred brand drugs (Tier 2)	Retail-30 day supply-2 fills; 40% coinsurance with min charge of \$25 or actual cost if less	Not covered	Retail-90 day supply; \$50 co-pay. Prescriptions will not be filled at retail after 2 fills. Prior-authorization is required for certain brand name medications.
	Non-preferred brand drugs (Tier 3)	Retail-30 day supply-2 fills; 50% coinsurance with min charge of \$40 or actual cost if less	Not covered	Retail-90 day supply; \$75 co-pay. Prescriptions will not be filled at retail after 2 fills.
	Specialty drugs	Covered	Not covered	Must be dispensed by the Specialty Pharmacy Program Provider. Precertification required contact NYC Healthline at 1-800-521-9574.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Please check with your employer.
	Physician/surgeon fees	Covered	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	-----None-----
If you need immediate medical attention	Emergency room care	Not covered	Not covered	-----None-----
	Emergency medical transportation	Not covered	20% coinsurance	No air ambulance or ambulette service
	Urgent care	Preferred: \$50 co-pay per visit Non-Preferred: \$100 co-pay per visit	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	Please check with your employer.
	Physician/surgeon fee	Covered	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	-----None-----

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

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Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Preferred: \$0 co-pay per visit Non-Preferred: \$15 co-pay per visit	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	No prior approval required
	Inpatient services	\$300 co-pay per admission/\$750 maximum per calendar year	\$500 co-pay per admission/\$1,250 maximum per calendar year. 20% to max of \$2,000 per person per calendar year.	Pre-certification required
If you are pregnant	Office visits	No charge	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	-----None-----
	Childbirth/delivery professional services	No charge	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	-----None-----
	Childbirth/delivery facility services	No charge	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	Enhanced schedule increases the reimbursement of the basic program's non-participating provider fee schedule, on average, by 75%. Pre-certification required contact NYC Healthline at 1-800-521-9574.

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 need help recovering or have other special health needs	Home health care	No charge	\$50 deductible per episode; 20% coinsurance insurance	200 visits per member per plan year. Preauthorization required.
	Rehabilitation services	Preferred: \$0 co-pay per visit Non-Preferred: \$20 co-pay per visit	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	Coverage limited to 16 visits per calendar year. Pre-certification required for additional visits
	Habilitation services	Preferred: \$0 co-pay per visit Non-Preferred: \$20 co-pay per visit	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	
	Skilled nursing care	Not covered	Not covered	-----None-----
	Durable medical equipment	\$100 deductible	\$100 deductible; 50% of usual and customary charge	Pre-certification required on greater than \$2,000 call NYC Healthline at 1-800-521-9574.
	Hospice services	Not covered	Not covered	-----None-----
If your child needs dental or eye care	Children's eye exam	Not covered	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 policy or [plan](#) document for more information and a list of any other [excluded services](#).)**

- | | | |
|--------------------|--|------------------------|
| • Acupuncture | • Hearing aids | • Routine eye care |
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care | • Most coverage provided outside the United States | • Weight loss programs |
| | • 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](#) document.)

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|---|---|------------------------|
| • Bariatric surgery (Prior Approval required) | • Infertility treatment (Prior Approval required) | • Private-duty nursing |
| • Chiropractic 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 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: 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

<p><u>For HMO Coverage</u> 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</p>	<p><u>Consumer Assistance Program</u> 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 <u>For Group Coverage:</u> U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) Website: www.dol.gov/ebsa/healthreform</p>
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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 1-800-624-2414

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): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-624-2414

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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) \$30
- Hospital (facility) [cost sharing](#) Check with your employer
- 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	\$12,800
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In the example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$440
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$96
The total Peg would pay is	\$536

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) \$30
- Hospital (facility) [cost sharing](#) Check with your employer
- Other [cost sharing](#) \$55

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
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In the example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,150
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,205

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) (cost sharing) \$30
- Hospital (facility) [cost sharing](#) Check with your employer
- Other [cost sharing](#) \$595

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
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In the example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$37
Copayments	\$260
Co-insurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$595
The total Mia would pay is	\$892



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 (Traditional 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**).

(Arabic) العربية

يُرجى الانتباه: تتوفر لك خدمات المساعدة اللغوية مجاناً، 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).

(Urdu) اردو

توجہ 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.