
 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 1-800-447-8255. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-447-8255 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible ? | In-Network: \$6,300 individual / \$12,600 family. | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| Are there services covered before you meet your deductible ? | Yes. Preventive care , generic drugs, telemedicine and acupuncture are covered before you meet your 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? | There are no other specific deductibles . | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | For participating providers \$9,100 individual / \$18,200 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 , the overall family out-of-pocket limit must be met. |
| What is not included in the out-of-pocket limit ? | Premiums , balance-billing 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 1-800-447-8255 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 a non-participating 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 ? | 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 |
|---|--|--|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating 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 | 50% coinsurance after deductible | Not Covered | First visit (any combination of PCP, ABA, MH/SUD) covered in full. |
| | Specialist visit | 50% coinsurance after deductible | Not Covered | None |
| | Preventive care / screening / immunization | No Charge | Not Covered | None |
| If you have a test | Diagnostic test (x-ray, blood work) | Xray: 50% coinsurance after deductible , Lab: 50% coinsurance after deductible | Not Covered | Preauthorization may be required. |
| | Imaging (CT/PET scans, MRIs) | 50% coinsurance after deductible | Not Covered | Preauthorization 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) | \$50 copayment not subject to deductible (retail); \$125 copayment not subject to deductible (mail order) | Not Covered (retail); Not Covered (mail order) | Preauthorization is not required for a covered prescription drug used to treat a substance use disorder, including a prescription drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. Your cost may be higher if you select a brand name drug when a generic medicine is available. This plan has a Preferred Pharmacy Network which excludes CVS |
| | Preferred brand drugs (Tier 2) | 50% coinsurance after deductible (retail); 50% coinsurance after deductible (mail order) | Not Covered (retail); Not Covered (mail order) | |
| | Non-preferred brand drugs (Tier 3) | 50% coinsurance after deductible (retail); 50% coinsurance after deductible (mail order) | Not Covered (retail); Not Covered (mail order) | |
| | Specialty drugs (Tier 4) | After deductible: Tier 1: \$50 copay/30 day supply Tier 2: 50% coinsurance /30 day supply Tier 3: 50% coinsurance /30 day supply (specialty retail only) | Not Covered (specialty retail only) | |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 50% coinsurance after deductible | Not Covered | Preauthorization required. |
| | Physician/surgeon fees | 50% coinsurance after deductible | Not Covered | Preauthorization required. |
| If you need immediate medical attention | Emergency room care | 50% coinsurance after deductible | 50% coinsurance after deductible | Waived if admitted to Hospital. |
| | Emergency medical transportation | 50% coinsurance after deductible | 50% coinsurance after deductible | None |
| | Urgent care | 50% coinsurance after deductible | Not Covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 50% coinsurance after deductible , per admission | Not Covered | Preauthorization required, except for emergency admissions. |
| | Physician/surgeon fees | 50% coinsurance after deductible | Not Covered | Preauthorization required. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visits: 50% coinsurance after deductible All Other Outpatient Services: 50% coinsurance after deductible | Not Covered | First visit (any combination of PCP, ABA, MH/SUD) covered in full. Unlimited visits. For Substance Abuse care, up to twenty (20) visits per plan year may be used for family counseling. |
| | Inpatient services | 50% coinsurance after deductible , per admission | Not Covered | Preauthorization required, except for emergency admissions. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|----------------------|---|--|---|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you are pregnant | Office visits | No Charge | Not Covered | Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA will use the cost sharing for the appropriate service. |
| | Childbirth/delivery professional services | 50% coinsurance after deductible | Not Covered | Preauthorization required. |
| | Childbirth/delivery facility services | 50% coinsurance after deductible , per admission | Not Covered | Limited to forty-eight (48) hours for natural delivery and ninety-six (96) hours for caesarean delivery. One (1) home care visit covered in full if discharged early. Preauthorization required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | 50% coinsurance after deductible | Not Covered | Forty (40) visits per plan year. Preauthorization required. |
| | Rehabilitation services | Inpatient: 50% coinsurance after deductible , per admission Outpatient: 50% coinsurance after deductible | Not Covered | Inpatient: Sixty (60) days per condition/per plan year, combined therapies. Outpatient: Sixty (60) visits per condition/per plan year, combined therapies. Preauthorization required. |
| | Habilitation services | Inpatient: 50% coinsurance after deductible , per admission Outpatient: 50% coinsurance after deductible | Not Covered | Inpatient: Sixty (60) days per condition/per plan year, combined therapies. Outpatient: Sixty (60) visits per condition/per plan year, combined therapies. Preauthorization required. |
| | Skilled nursing care | 50% coinsurance after deductible , per admission | Not Covered | Preauthorization required. |
| | Durable medical equipment | 50% coinsurance after deductible | Not Covered | None |
| | Hospice services | Inpatient: 50% coinsurance after deductible Outpatient: 50% coinsurance after deductible | Not Covered | 210 days per plan year. Five (5) visits for family bereavement counseling. Preauthorization required. |
| If your child needs dental or eye care | Children's eye exam | No Charge | Not Covered | One (1) exam per twelve (12) month period. |
| | Children's glasses | 50% coinsurance not subject to deductible | Not Covered | One (1) prescribed lenses and frames per twelve (12)-month period. |
| | Children's dental check-up | \$40 copayment not subject to deductible | Not Covered | One (1) dental exam & cleaning per six (6)-month period. Full mouth x-rays or panoramic x-rays. |

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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Routine hearing tests
- Weight loss programs

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

- Acupuncture
- Bariatric Surgery (Prior Approval required)
- Chiropractic care
- Hearing aids (Prior Approval required)
- 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 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 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 rights, 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 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

Coming Tower - OCP Room 1607

Albany, NY 12237

Email: managedcarecomplaint@health.ny.govWebsite: 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.orgWebsite: 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 Coverage Meet the Minimum Value Standard? 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 1-888-447-8255

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-447-8255

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-447-8255

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-447-8255

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

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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](#) \$6300
- [Specialist coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [copayment](#) \$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 | \$6,300 |
| Copayments | \$1,190 |
| Coinsurance | \$4,915 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$12,465 |

Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$6300
- [Specialist coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [copayment](#) \$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 | \$6,300 |
| Copayments | \$2,255 |
| Coinsurance | \$2,412 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$11,022 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$6300
- [Specialist coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [copayment](#) \$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 | \$6,300 |
| Copayments | \$210 |
| Coinsurance | \$816 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$7,326 |

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-390-3522.

*Note: This [plan](#) may have other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services



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**).

العربية (Arabic)

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**).

اردو (Urdu)

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.