

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
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, \$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, \$150 for prescription drugs and \$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). 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 Participating: \$15 co-pay per visit	0% coinsurance	----None----
	Specialist visit	Preferred: \$0 co-pay per visit Participating: \$30 co-pay per visit	0% coinsurance	Lower co-pay applies when a Preferred Provider refers
	Preventive care/screening/immunization	No charge	0% coinsurance	----None----
If you have a test	Diagnostic test (x-ray, blood work)	\$20 co-pay per visit	0% coinsurance	----None----
	Imaging (CT/PET scans, MRIs)	\$50 co-pay per visit	0% 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)	Retail-30 days supply-2 fills; Deductible \$150 ind/\$450 fam; 20% coinsurance with min charge of \$5 or actual cost if less	Not covered	Mandatory mail order - 60 day supply; \$10 co-pay. Prescriptions will not be filled at retail after 2 fills.
	Preferred brand drugs (Tier 2)	Retail-30 days supply-2 fills; Deductible \$150 ind/\$450 fam; 40% coinsurance with min charge of \$25 or actual cost if less	Not covered	Mandatory mail order - 60 day supply; \$40 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 days supply-2 fills; Deductible \$150 ind/\$450 fam; 50% coinsurance with min charge of \$40 or actual cost if less	Not covered	Mandatory mail order - 60 day supply; \$60 co-pay. Prescriptions will not be filled at retail after 2 fills.
	Specialty drugs (Tier 4)	Covered	Not covered	Must be dispensed by the Specialty Pharmacy Program Provider. Precertification required contact NYC Healthline at 1-800-521-9574.

* 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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Please check with your employer.
	Physician/surgeon fees	Covered	0% coinsurance	-----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	\$50 co-pay per visit	0% coinsurance	-----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	0% coinsurance	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Preferred: \$0 co-pay per visit Participating: \$15 co-pay per visit	0% coinsurance	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	0% coinsurance	-----None-----
	Childbirth/delivery professional services	No charge	0% coinsurance	-----None-----
	Childbirth/delivery facility services	No charge	0% coinsurance	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 Participating: \$30 co-pay per visit	0% coinsurance	Coverage limited to 16 visits per calendar year. Pre-certification required for additional visits
	Habilitation services	Preferred: \$0 co-pay per visit Participating: \$30 co-pay per visit	0% coinsurance	
	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 foot care |
| • Cosmetic surgery | • Long-term care | • Weight loss programs |
| • Dental care (Adult) | • Most coverage provided outside the United States | |
| | • 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.)

- | | | |
|---|---|----------------------------|
| • Bariatric surgery (Prior Approval required) | • Infertility treatment (Prior Approval required) | • Private-duty nursing |
| • Chiropractic care | | • Routine eye care (Adult) |

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 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:

<p><u>EmblemHealth</u> 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</p>	<p><u>For All Coverage Types</u> 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>
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* For more information about limitations and exceptions, see the plan or policy document at www.emblemhealth.com/sbc.

<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</p> <p><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

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 1-800-624-2414
- 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): Dinek'ehgo 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.*—————

* 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)

- 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

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

In the example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$1,150
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,355

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

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

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 1-800-318-2596.

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



GETTING HELP IN A LANGUAGE OTHER THAN ENGLISH

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：這是重要的文件。如果您需要協助來瞭解文件內容，請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)

주의: 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 udenti: 711). Possiamo mettere a disposizione gratis un interprete nella Sua lingua.

אײַדיש (Yiddish)

מעלדונג: דאס איז א וויכטיגע דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט דעם טעלעפון נומבער גערופן “customer service” אויף אייער קארטל [TTY/TDD: 711]. מיר קענען אייך געבן אן איבערזעצער פריי אין די שפראך וואס איר רעדט.

বাংলা (Bengali)

দৃষ্টি আকর্ষণ করছি: এটি একটি গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয়, তাহলে অনুগ্রহ করে আপনার মেম্বার আইডি কার্ডের উল্টোপাঠে "customer service" চিহ্নিত টেলিফোন নম্বরে [TTY/TDD: 711] কল করুন। আপনি যে ভাষায় কথা বলেন সে-ভাষার জন্য বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

Polski (Polish)

UWAGA: To jest ważny dokument. Jeżeli potrzebujesz pomocy w celu zrozumienia jego treści, zadzwoń do „customer service” pod numer telefonu podany na odwrocie karty identyfikacyjnej ubezpieczonego (member ID card) [TTY/TDD: 711]. Możemy bezpłatnie zapewnić usługi tłumacza języka, którym się posługujesz.

العربية (ARABIC)

انتباه: هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم المشار إليه بـ "customer service" على ظهر بطاقة عضويتك [711:TTY/TDD]. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجاناً.

Français (French)

ATTENTION : ce document est important. Si vous avez besoin d'aide pour en comprendre le contenu, veuillez composer le numéro «customer service » au dos de votre carte de membre [Sourds et malentendants : 711]. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

اردو (Urdu)

توجہ دیں: یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم "customer service" والے نمبر پر کال کریں جو آپ کے ممبر آئی ڈی کارڈ کی پشت پر درج ہے [ٹی ٹی وائی/ٹی ڈی ڈی: 711]۔ آپ جو زبان بولتے ہیں اس میں ہم آپ کو مفت مترجم فراہم کرسکتے ہیں۔

Tagalog (Tagalog)

NANAWAGAN NG PANSIN: Ito ay isang mahalagang dokumento. Kung kailangan mo ng tulong para maintindihan ito, pakitawagan ang numero ng telepono na minarkahang "customer service" sa likod ng inyong ID card ng miyembro [TTY/TDD: 711]. Maaari ka naming bigyan ng libreng interpreter sa wikang iyong sinasalita.

Ελληνικά (Greek)

ΠΡΟΣΟΧΗ: Αυτό το έγγραφο είναι σημαντικό. Εάν χρειάζεστε βοήθεια για να το κατανοήσετε, καλέστε μας στον αριθμό που σημειώνεται ως «customer service» στο πίσω μέρος της κάρτας της συνδρομής σας [αριθμός για άτομα με προβλήματα ακοής (TTY/TDD): 711]. Μπορούμε να σας προσφέρουμε δωρεάν διερμηνεία στη μητρική σας γλώσσα.

Shqip (Albanian)

VINI RE: Ky është një dokument i rëndësishëm. Nëse ju nevojitet ndihmë për ta kuptuar, ju lutemi telefononi në numrin ku shkruhet "customer service", i cili gjendet ne anen e pasme të kartës tuaj identifikuese të anëtarësisë [Shërbimi rele TTY/TDD: 711]. Ne mund t'ju ofrojmë pa pagesë një përkthyes në gjuhën që flisni ju.

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.