



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, \$2,500 Individual / \$5,000 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 medical and hospital services are not subject to a deductible. All covered 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?	Yes, accumulates plan year, \$100 deductible for Brand prescription drugs and \$100 deductible 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 \$6,600 Individual / \$13,200 Family, accumulates plan year.	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 1-800-447-8255 for a list of participating providers in the Prime Network.	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. A referral is required to see a specialty care provider (SCP).	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.

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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 co-pay visit	After Plan deductible is met, 50% coinsurance	-----None-----
	<u>Specialist</u> visit	\$40 co-pay visit	After Plan deductible is met, 50% coinsurance	-----None-----
	<u>Preventive care/screening/immunization</u>	No charge	After Plan deductible is met, 50% coinsurance	Applies to most services in accordance with USPSTF and HRSA including: Well Child Visits; Adult Annual Physical Exams; Well Woman Exams; Bone Density Testing.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	PCP office: No charge SCP office: No charge	After Plan deductible is met, 50% coinsurance	-----None-----
	Imaging (CT/PET scans, MRIs)	SCP office: No charge Radiology Facility: No charge	After Plan deductible is met, 50% coinsurance	Preauthorization required
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.EmblemHealth.com .	Generic drugs (Tier 1)	Retail: \$15 co-pay/30 day supply Mail Order: \$22.50 co-pay/90 day supply	Not covered	Tier 1, Tier 2, and Tier 3 drugs are covered. Brand drugs subject to plan year Rx deductible of \$100 before copay applies.
	Preferred brand drugs (Tier 2)	Retail: \$35 co-pay/30 day supply Mail Order: \$52.50 co-pay/90 day supply	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: \$75 co-pay/30 day supply Mail Order: \$112.50 co-pay/90 day supply	Not covered	
	<u>Specialty drugs</u>	Tier 1: \$15 co-pay/30 day supply Tier 2: \$35 co-pay/30 day supply Tier 3: \$75 co-pay/30 day supply	Not covered	Brand drugs subject to plan year Rx deductible before copay applies. Written referral required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Facility: \$75 co-pay visit Outpatient Facility: \$75 co-pay visit	After Plan deductible is met, 50% coinsurance	Preauthorization required
	Physician/surgeon fees	No charge	After Plan deductible is met, 50% coinsurance	-----None-----

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 immediate medical attention	Emergency room care	\$100 co-pay	\$100 co-pay	Applies to facility charge, waived if admitted.
	Emergency medical transportation	No charge	No charge	-----None-----
	Urgent care	\$20 co-pay visit	After Plan deductible is met, 50% coinsurance	Applies to facility charge.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 per admission	After Plan deductible is met, 50% coinsurance	Preauthorization required
	Physician/surgeon fee	No charge	After Plan deductible is met, 50% coinsurance	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental & Behavioral Health: \$20 co-pay visit Substance Abuse: \$20 co-pay visit	After Plan deductible is met, 50% coinsurance	Unlimited visits. For Substance Abuse care, up to 20 visits per plan year may be used for family counseling
	Inpatient services	\$500 per admission	After Plan deductible is met, 50% coinsurance	Preauthorization required. However, Preauthorization is not required for emergency admissions.
If you are pregnant	Office visits	\$20 co-pay visit	After Plan deductible is met, 50% coinsurance	Pre/Postnatal Care provided in accordance with USPSTF and HRSA has No charge.
	Childbirth/delivery professional services	No charge	After Plan deductible is met, 50% coinsurance	Preauthorization required
	Childbirth/delivery facility services	\$500 per admission	After Plan deductible is met, 50% coinsurance	Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Preauthorization 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 help recovering or have other special health needs	Home health care	No charge	After Plan deductible is met, 50% coinsurance	200 visits per plan year. Preauthorization required.
	Rehabilitation services	Inpatient: \$500 per admission SCP office: \$40 co-pay visit	After Plan deductible is met, 50% coinsurance	Inpatient: 90 days per plan year combined therapies. Preauthorization required.
	Habilitation services	Inpatient: \$500 per admission SCP office: \$40 co-pay visit	After Plan deductible is met, 50% coinsurance	Outpatient: 90 visits per plan year combined therapies. Preauthorization required.
	Skilled nursing care	No charge	Not covered	Unlimited days per plan year. Preauthorization required.
	Durable medical equipment	After DME deductible is met, No charge	Not covered	Preauthorization required
	Hospice services	No charge	Not covered	210 days per plan year. Preauthorization required.
If your child needs dental or eye care	Children's eye exam	No charge	After Plan deductible is met, 50% coinsurance	One refractive eye exam
	Children's glasses	Frames: \$80 allowance; Standard single, bifocal or trifocal lenses: \$35 co-pay	Not covered	Available every 24 months, calendar year, through participating EyeMed/ CPS providers
	Children's dental check-up	\$5 co-pay/visit	Not covered	Preventive Dental Care - One routine exam

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 | • 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 |

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



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)	\$40
■ Hospital (facility) cost sharing	\$0
■ Other cost sharing	\$61

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$11
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$61
The total Peg would pay is	\$72

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)	\$40
■ Hospital (facility) cost sharing	\$500
■ Other cost sharing	\$23

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:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$639
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$23
The total Joe would pay is	\$762

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist (cost sharing)	\$40
■ Hospital (facility) cost sharing	\$75
■ Other cost sharing	\$248

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$428
Co-insurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$248
The total Mia would pay is	\$676

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

PPSTD5824