EmblemHealth City of New York

**Coverage Period:** 07/01/2026 - 06/30/2027

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

**EmblemHealth : HIP HMO Preferred** **Coverage for:** Individual/Family **Plan Type:** HMO

**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 1-833-269-4653. 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 1-833-269-4653 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 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?** | No | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For in network providers $3,300 Individual / $6,600 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 1-800-447-8255 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.

| 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 visit<br>Non-Preferred: $10 co-pay visit | Not covered | -----None----- |
| | Specialist visit | Preferred: $0 co-pay visit<br>Non-Preferred: $10 co-pay visit | Not covered | Referral required. Infusion Therapy in Outpatient Hospital $100 co-pay per incident. |
| | Preventive care/screening/ immunization | No charge | Not covered | Applies to Well Child Visits; Adult Annual Physical Exams; Well Woman Exams; Bone Density Testing. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Preferred: $0 co-pay visit<br>Non-Preferred: $10 co-pay visit<br>Outpatient Hospital: $100 co-pay visit | Not covered | Referral required for Specialist Office and Outpatient Hospital. |
| | Imaging (CT/PET scans, MRIs) | Preferred: $0 co-pay visit<br>Non-Preferred: $10 co-pay visit<br>Outpatient Hospital: $100 co-pay visit | Not covered | Referral 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: 20% coinsurance, but not less than a $5 co-pay/30 day supply<br>Mail Order: $12.50 co-pay/90 day supply | Not covered | Tier 1, Tier 2, and Tier 3 drugs are covered. |
| | Preferred brand drugs (Tier 2) | Retail: 40% coinsurance, but not less than a $25 co-pay/30 day supply<br>Mail Order: $50 co-pay/90 day supply | Not covered | |
| | Non-preferred brand drugs (Tier 3) | Retail: 50% coinsurance, but not less than a $40 co-pay/30 day supply<br>Mail Order: $75 co-pay/90 day supply | Not covered | |
| | Specialty drugs | Tier 1: 20% coinsurance, but not less than a $5 co-pay/30 day supply<br>Tier 2: 40% coinsurance, but not less than a $25 co-pay/30 day supply<br>Tier 3: 50% coinsurance, but not less than a $75 co-pay/30 day supply | Not covered | Written referral required. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Ambulatory Facility: $50 co-pay<br>Outpatient Hospital: $150 co-pay | Not covered | Preauthorization required |
| | Physician/surgeon fees | No charge | Not covered | Preauthorization required |
| **If you need immediate medical attention** | Emergency room care | $150 co-pay | $150 co-pay | Applies to facility charge, waived if admitted. |
| | Emergency medical transportation | No charge | No charge | -----None----- |
| | Urgent care | $50 co-pay per visit | Not covered | -----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 have a hospital stay** | Facility fee (e.g., hospital room) | $100 per admission | Not covered | Preauthorization required |
| | Physician/surgeon fee | No charge | Not covered | Preauthorization required |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Preferred: $0 co-pay visit<br>Non-Preferred: $10 co-pay visit | Not covered | Unlimited visits. For Substance Abuse care, up to 20 visits per calendar year may be used for family counseling |
| | Inpatient services | $100 per admission | Not covered | Preauthorization required. However, Preauthorization is not required for emergency admissions. |
| **If you are pregnant** | Office visits | No charge | Not covered | -----None----- |
| | Childbirth/delivery professional services | No charge | Not covered | Preauthorization required |
| | Childbirth/delivery facility services | $100 per admission | Not covered | Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Preauthorization required |
| **If you need help recovering or have other special health needs** | Home health care | No charge | Not covered | 200 visits per plan year. Preauthorization required. |
| | Rehabilitation services | Inpatient: $100 per admission<br>Outpatient: Preferred: $0 co-pay visit<br>Non-Preferred: $10 co-pay visit | Not covered | Inpatient: 90 days per plan year combined therapies. Preauthorization required.<br>Outpatient: 90 visits per plan year combined therapies. Preauthorization required. |
| | Habilitation services | Inpatient: $100 per admission<br>Outpatient: Preferred: $0 co-pay visit<br>Non-Preferred: $10 co-pay visit | Not covered | |
| | Skilled nursing care | No charge | Not covered | Unlimited days. Preauthorization required. |
| | Durable medical equipment | No charge | Not covered | Preauthorization required |
| | Hospice services | No charge | Not covered | 210 days per plan year. 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 your child needs dental or eye care** | Children's eye exam | Preferred: $0 co-pay visit<br>Non-Preferred: $10 co-pay visit | Not covered | Refractive eye exam |
| | Children's glasses | Frames: $80 allowance; Standard single, bifocal or trifocal lenses: $35 co-pay | Not covered | Available every 24 months through participating EyeMed/ CPS providers |
| | Children's dental check-up | Not covered | Not covered | |

## 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
- Non-emergency care when traveling outside the U.S.
- 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 (Prior Approval required)
- Chiropractic care
- Infertility treatment (Prior Approval required)
- Private-duty nursing
- 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/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**<br>**By Phone:**<br>Please call the number on your ID card.<br>**In writing:**<br>EmblemHealth<br>Grievance and Appeals Department<br>P.O. Box 2801<br>New York, NY 10116-2807<br>Website: www.emblemhealth.com | **For All Coverage Types**<br>**New York State Department of Financial Services**<br>**By Phone**: 1-800-342-3736<br>**In writing**:<br>New York State Department of Financial Services<br>Consumer Assistance Unit<br>One Commerce Plaza<br>Albany, NY 12257<br>Website: www.dfs.ny.gov |

| For HMO Coverage | Consumer Assistance Program |
|---|---|
| **New York State Department of Health**<br>**By Phone:** 1-800-206-8125<br>**In writing:**<br>New York State Department of Health<br>Office of Health Insurance Programs<br>Bureau of Consumer Services – Complaint Unit<br>Corning Tower – OCP Room 1607<br>Albany, NY 12237<br>Email: managedcarecomplaint@health.ny.gov<br>Website: www.health.ny.gov | **New York State Consumer Assistance Program**<br>**By Phone:** 1-888-614-5400<br>**In writing:**<br>Community Health Advocates<br>633 Third Avenue, 10th Floor<br>New York, NY 10017<br>Email: cha@cssny.org<br>Website: www.communityhealthadvocates.org<br>**For Group Coverage:**<br>**U.S. Department of Labor**<br>**Employee Benefits Security Administration** at 1-866-444-EBSA (3272)<br>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 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, kwiijigo 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)** | $10 |
| **Hospital (facility) cost sharing** | $100 |
| **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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $321 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $61 |
| **The total Peg would pay is** | $382 |

## 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)** | $10 |
| **Hospital (facility) cost sharing** | $100 |
| **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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $413 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $23 |
| **The total Joe would pay is** | $436 |

## Mia's Simple Fracture

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

| | |
|---|---|
| **The plan's overall deductible** | $0 |
| **Specialist (cost sharing)** | $10 |
| **Hospital (facility) cost sharing** | $150 |
| **Other cost sharing** | $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 the example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $288 |
| Co-insurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $288 |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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**Notice of Availability of Language Assistance Services and Auxiliary Aids and Services**

**English** ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **877-411-3625** (TTY: **711**) or speak to your provider.

**Español (Spanish)** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **877-411-3625** (TTY: **711**) o hable con su proveedor.

**中文 (Simplified Chinese)** 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 **877-411-3625**（文本电话：**711**）或咨询您的服务提供商。

**РУССКИЙ (Russian)** ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **877-411-3625** (TTY: **711**) или обратитесь к своему поставщику услуг.

**Kreyòl Ayisyen (Haitian Creole)** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan **877-411-3625** (TTY: **711**) oswa pale avèk founisè w la.

**한국어 (Korean)** 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **877-411-3625** (TTY: **711**) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

**Italiano (Italian)** ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' **877-411-3625** (tty: **711**) o parla con il tuo fornitore.

(**Yiddish**) **יידיש** נאטיץ: אויב איר רעדט יידיש, שפראך הילף סערוויסעס זענען בארעכטיגט פאר דיר פריי. צונעמען אידס און באדינונגס פאר פראַוויידינג אינפאָרמאַציע אין צוטריטלעך פאָרמאַטירונגען זענען אויך בנימצא פריי. רופן **877-411-3625** (TTY: **711**) אָדער רעדן מיט דיין טרעגער.

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**বাংলা (Bengali)** মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। **877-411-3625** (TTY: **711**) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

**POLSKI (Polish)** UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **877-411-3625** (TTY: **711**) lub porozmawiaj ze swoim dostawcą.

**العربية (Arabic)**

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **877-411-3625** (**711**) أو تحدث إلى مقدم الخدمة.

**Français (French)** ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **877-411-3625** (TTY: **711**) ou parlez à votre fournisseur.

**اردو (Urdu)**

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (TTY: **711**) **877-411-3625** پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

**Tagalog (Tagalog)** PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **877-411-3625** (TTY: **711**) o makipag-usap sa iyong provider.

**Ελληνικά (Greek)** ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το **877-411-3625** (TTY: **711**) ή απευθυνθείτε στον πάροχό σας.

**SHQIP (Albanian)** VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi **877-411-3625** (TTY: **711**) ose bisedoni me ofruesin tuaj të shërbimit.

**NOTICE OF NONDISCRIMINATION POLICY**

Discrimination is Against the Law

EmblemHealth complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. EmblemHealth does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

## EmblemHealth:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters.
    - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters.
    - Information written in other languages.

## If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services contact the Civil Rights Coordinator by calling Customer Service at **877-411-3625** (TTY: **711**).

If you believe that EmblemHealth has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator by writing to the EmblemHealth Grievance and Appeals Department, P.O. Box 2844, New York, NY 10116-2844; faxing them at **212-510-5320**; or calling Customer Service at **877-411-3625**. (Dial **711** for TTY services.) You can file a grievance in person, by mail, by fax, or through your secure member portal. 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 for Civil Rights electronically through the Office for 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**; **800-368-1019** (TTY: **800-537-7697**).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

This notice is available on EmblemHealth's website at **emblemhealth.com/legal/nondiscrimination**.