

**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 1-800-624-2414. 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](http://www.emblemhealth.com) or call 1-800-624-2414 to request a copy.

| Important Questions   | Answers   | Why this Matters:  |
|---|---|--|
| What is the overall <a href="#">deductible</a> ?                                | \$0   | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | In network medical and hospital services are not subject to a deductible.   | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .  |
| Are there other <a href="#">deductibles</a> for specific services?              | No  | You don't have to meet <a href="#">deductibles</a> for specific services.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For in network providers \$3,300 Individual / \$6,600 Family.   | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | 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 <a href="#">out-of-pocket limit</a> .  |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.EmblemHealth.com">www.EmblemHealth.com</a> or call 1-800-447-8255 for a list of participating providers. | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). <b>Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</b> |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | Yes, written approval is required to see a specialist.  | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .   |



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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you visit a health care provider's office or clinic</b>   | Primary care visit to treat an injury or illness       | Preferred: \$0 co-pay visit<br>Participating: \$10 co-pay visit  | Not covered  | -----None-----   |
|   | <a href="#">Specialist</a> visit                       | Preferred: \$0 co-pay visit<br>Participating: \$10 co-pay visit  | Not covered  | Referral required. Infusion Therapy in Outpatient Hospital \$100 co-pay per incident.              |
|   | <a href="#">Preventive care/screening/immunization</a> | No charge  | Not covered  | Applies to Well Child Visits; Adult Annual Physical Exams; Well Woman Exams; Bone Density Testing. |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | Preferred: \$0 co-pay visit<br>Participating: \$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>Participating: \$10 co-pay visit<br>Outpatient Hospital: \$100 co-pay visit | Not covered  | Referral required  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.EmblemHealth.com">www.EmblemHealth.com</a> . | Generic drugs (Tier 1)                                 | Retail: \$5 co-pay/30 day supply<br>Mail Order: \$7.50 co-pay/90 day supply                                | Not covered  | Tier 1 and Tier 2 drugs are covered.   |
|   | Preferred brand drugs (Tier 2)                         | Retail: \$15 co-pay/30 day supply<br>Mail Order: \$22.50 co-pay/90 day supply                              | Not covered  |  |
|   | Non-preferred brand drugs (Tier 3)                     | Not Covered  | Not covered  |  |
|   | <a href="#">Specialty drugs</a>                        | Tier 1: \$5 co-pay/30 day supply<br>Tier 2: \$15 co-pay/30 day supply                                      | Not covered  | Written referral required.   |
| <b>If you have outpatient surgery</b>   | 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  |

\* For more information about limitations and exceptions, see the plan or policy document at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).

| Common Medical Event  | Services You May Need                            | What You Will Pay   |  | *Limitations, Exceptions, & Other Important Information   |
|---|--|---|--|---|
|   |  | Network Provider<br>(You will pay the least)                    | Out-of-Network Provider<br>(You will pay the most) |   |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$150 co-pay  | \$150 co-pay                                       | Applies to facility charge, waived if admitted.   |
|   | <a href="#">Emergency medical transportation</a> | No charge   | No charge  | -----None-----  |
|   | <a href="#">Urgent care</a>                      | \$50 co-pay visit   | Not covered  | -----None-----  |
| 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>Participating: \$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         |

| Common Medical Event  | Services You May Need                     | What You Will Pay   |  | *Limitations, Exceptions, & Other Important Information                            |
|---|---|---|--|--|
|   |   | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | No charge   | Not covered  | 200 visits per plan year. Preauthorization required.                               |
|   | <a href="#">Rehabilitation services</a>   | Inpatient: \$100 per admission<br>Outpatient: Preferred: \$0 co-pay visit<br>Participating: \$10 co-pay visit | Not covered  | Inpatient: 90 days per plan year combined therapies. Preauthorization required.    |
|   | <a href="#">Habilitation services</a>     | Inpatient: \$100 per admission<br>Outpatient: Preferred: \$0 co-pay visit<br>Participating: \$10 co-pay visit | Not covered  | Outpatient: 90 visits per plan year combined therapies. Preauthorization required. |
|   | <a href="#">Skilled nursing care</a>      | No charge   | Not covered  | Unlimited days. Preauthorization required.   |
|   | <a href="#">Durable medical equipment</a> | No charge   | Not covered  | Preauthorization required  |
|   | <a href="#">Hospice services</a>          | No charge   | Not covered  | 210 days per plan year. Preauthorization required.                                 |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | Preferred: \$0 co-pay visit<br>Participating: \$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      | • 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/](http://www.dfs.ny.gov/), U.S. Department of Health and Human Services at 1-877-267-2323 x1565 or [www.cciio.cms.gov](http://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](http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html) or [www.dol.gov/ebsa/healthreform](http://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](http://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:

**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](http://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](http://www.dfs.ny.gov)

|   |   |
|---|---|
| <p><b><u>For HMO Coverage</u></b><br/> <b>New York State Department of Health</b><br/> <b>By Phone:</b> 1-800-206-8125<br/> <b>In writing:</b><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: <a href="mailto:managedcarecomplaint@health.ny.gov">managedcarecomplaint@health.ny.gov</a><br/> Website: <a href="http://www.health.ny.gov">www.health.ny.gov</a></p> | <p><b><u>Consumer Assistance Program</u></b><br/> <b>New York State Consumer Assistance Program</b><br/> <b>By Phone:</b> 1-888-614-5400<br/> <b>In writing:</b><br/> Community Health Advocates<br/> 633 Third Avenue, 10<sup>th</sup> Floor<br/> New York, NY 10017<br/> Email: <a href="mailto:cha@cssny.org">cha@cssny.org</a><br/> Website: <a href="http://www.communityhealthadvocates.org">www.communityhealthadvocates.org</a></p> <p><b><u>For Group Coverage:</u></b><br/> <b>U.S. Department of Labor</b><br/> <b>Employee Benefits Security Administration</b> at 1-866-444-EBSA (3272)<br/> Website: <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a></p> |
|---|---|

**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.*—————



**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](#) \$60

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)

|                           |          |
|---------------------------|----------|
| <b>Total Example Cost</b> | \$12,800 |
|---------------------------|----------|

In the example, Peg would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$320        |
| <a href="#">Coinsurance</a>       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$380</b> |

### 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](#) \$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)

|                           |         |
|---------------------------|---------|
| <b>Total Example Cost</b> | \$7,400 |
|---------------------------|---------|

In the example, Joe would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$780        |
| <a href="#">Coinsurance</a>       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$55         |
| <b>The total Joe would pay is</b> | <b>\$835</b> |

### 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](#) \$50
- [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)

|                           |         |
|---------------------------|---------|
| <b>Total Example Cost</b> | \$1,900 |
|---------------------------|---------|

In the example, Mia would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$130        |
| <a href="#">Co-insurance</a>      | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$130</b> |

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**).



**(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

توجه 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](https://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](https://hhs.gov/ocr/office/file/index.html).