



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.emblemhealth.com or by calling **1-800-624-2414**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$200 individual/\$500 family for out-of-network only.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes	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.
Is there an out-of-pocket limit on my expenses?	Yes, For 7/01/16 - 12/31/16 the limit is \$2,175 individual / \$4,350 family For 1/01/17 - 12/31/17 the limit is \$4,550 individual / \$9,100 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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 .
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.EmblemHealth.com or call 1-877-842-3625 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

Questions: Call **1-800-624-2414** or visit us at www.emblemhealth.com/sbc.

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
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 Participating: \$15 co-pay/visit	0% co-insurance	----None----
	Specialist visit	Preferred: \$0 co-pay/visit Participating: \$30 co-pay/visit	0% co-insurance	Lower co-pay applies when a Preferred provider refers
	Other practitioner office visit	Chiropractor: \$15 co-pay/visit	0% co-insurance	----None----
	Preventive care/screening/immunization	Preferred: No charge Participating: No charge	0% co-insurance	----None----
If you have a test	Diagnostic test (x-ray, blood work)	\$20 co-pay/visit	0% co-insurance	----None----
	Imaging (CT/PET scans, MRIs)	\$50 co-pay/visit	0% co-insurance	Pre-certification required.
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	----None----
	Preferred brand drugs	Not covered	Not covered	----None----
	Non-preferred brand drugs	Not covered	Not covered	----None----
More information about prescription drug coverage is available at www.EmblemHealth.com .	Specialty drugs	Not covered	Not covered	----None----

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
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% co-insurance	----None----
If you need immediate medical attention	Emergency room services	Not covered	Not covered	----None----
	Emergency medical transportation	Not covered	20% co-insurance	No air ambulance or ambulette service
	Urgent care	\$50 co-pay/visit	0% co-insurance	----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% co-insurance	----None----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Preferred: \$0 co-pay/visit Participating: \$15 co-pay/visit	0% co-insurance	No prior approval required
	Mental/Behavioral health 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
	Substance use disorder outpatient services	Preferred: \$0 co-pay/visit Participating: \$15 co-pay/visit	0% co-insurance	No prior approval required
	Substance use disorder inpatient services	\$300 co-pay per admission/\$750 maximum per calendar year	\$500 co-pay per admission/\$1,250 maximum per calendar year	----None----
If you are pregnant	Prenatal and postnatal care	No charge	0% co-insurance	----None----
	Delivery and all inpatient services	No charge	0% co-insurance	Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Prior approval required

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	\$50 deductible per episode; 20% co-insurance	200 visits per member per year. Pre-certification required.
	Rehabilitation services	Preferred: \$0 co-pay/visit Participating: \$30 co-pay/visit	0% co-insurance	Coverage limited to 16 visits per calendar year. Pre-certification required for additional visits
	Habilitation services	Preferred: \$0 co-pay/visit Participating: \$30 co-pay/visit	0% co-insurance	
	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 service	Not covered	Not covered	----None----
If your child needs dental or eye care	Eye exam	Preferred: \$0 co-pay/visit Participating: \$30 co-pay/visit	Not covered	----None----
	Glasses	\$45 co-pay/pair	Not covered	Limited to one pair every twenty-four (24) months from an authorized provider
	Dental check-up	Not covered	Not covered	----None----

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care 	<ul style="list-style-type: none"> • Hearing aids • Long-term care 	<ul style="list-style-type: none"> • Routine foot care • Weight loss programs

Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Infertility treatment	• Private-duty nursing

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|---------------------|--|--------------------|
| • Chiropractic care | • Non-emergency care when traveling outside the U.S. | • Routine eye care |
|---------------------|--|--------------------|

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact EmblemHealth at 1-800-624-2414. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.”

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact EmblemHealth.

<p>All hospital grievances should be mailed to: EmblemHealth-Hospital Grievance P.O. Box 2828 New York, New York 10116-2828 All other grievances should be mailed to: EmblemHealth-Grievance Unit P.O. Box 1701 New York, New York 10023-9476 Oral Utilization Review Appeals can be initiated by calling toll free 888-906-7668.</p>	<p>Or you may submit a written appeal to: EmblemHealth Utilization Review Appeals P.O. Box 2809 New York, NY 10116-2809 You may also obtain an external appeal application from: The New York State Department of Financial Services at 1-800-400-8882, or its Web site (www.dfs.ny.gov/), or The EmblemHealth Medical/Utilization Review Department at 1-877-482-3625</p>
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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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.

Questions: Call **1-800-624-2414** or visit us at www.emblemhealth.com/sbc.

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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 page.

Questions: Call **1-800-624-2414** or visit us at **www.emblemhealth.com/sbc**.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$7315
- **Patient pays** \$225

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Co-pays	\$75
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$225

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-800-624-2414.

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** 4125.47
- **Patient pays** 1274.53

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Co-pays	\$535
Co-insurance	0
Limits or exclusions	\$739.53
Total	1274.53

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-624-2414.

Questions: Call 1-800-624-2414 or visit us at www.emblemhealth.com/sbc.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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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.

אידיש (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 উল্টোপাশে “customer service” চিহ্নিত টেলিফোন নম্বরে [TTY/TDD: 711] কল করুন। আপনি যে ভাষায় কথা

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 [TTY/TDD: 711]. 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.