



Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	No	There is no out-of-pocket limit on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, penalties, balanced-bill charges and health care this plan does not cover.	Not applicable because there's no <b>out-of-pocket limit</b> on your expenses.
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 <u>network of providers</u> ?	Yes. See <a href="http://www.emblemhealth.com">www.emblemhealth.com</a> or call 1-800-447-8255 for list of preferred and participating providers.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <u>specialist</u> ?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a <b>specialist</b> for covered services but only if you have the plan's permission before you see the <b>specialist</b> .
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b> .

Questions: Call 1-800-447-8255 or visit us at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc) or call 1-800-447-8255 to request a copy.



- **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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Preferred: \$0 co-pay/visit Participating: \$10 co-pay/visit	Not covered	-----None-----
	Specialist visit	Preferred: \$0 co-pay/visit Participating: \$10 co-pay/visit	Not covered	Lower copay applies for most services when a Preferred provider refers
	Other practitioner office visit	Chiropractor: Preferred: \$0 co-pay/visit Participating: \$10 co-pay/visit	Not covered	-----None-----
	Preventive care/screening/immunization	Preferred: No charge Participating: No charge (see Limitations & Exceptions)	Not covered	Copay applies to Vasectomy and Screening for Prostate Cancer when performed by Participating Provider
If you have a test	Diagnostic test (x-ray, blood work)	Preferred: \$0 co-pay/visit Participating: \$10 co-pay/visit	Not covered	-----None-----
	Imaging (CT/PET scans, MRIs)	Preferred: \$0 co-pay/visit Participating: \$10 co-pay/visit	Not covered	Prior approval 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	
	Non-preferred brand drugs	Not covered	Not covered	

Questions: Call 1-800-447-8255 or visit us at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc) or call 1-800-447-8255 to request a copy.



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
More information about <a href="http://www.EmblemHealth.com">prescription drug coverage</a> is available at <a href="http://www.EmblemHealth.com">www.EmblemHealth.com</a> .	Specialty drugs	Not covered	Not covered	-----None-----
<b>If you have outpatient surgery</b>	Facility fee	\$50 copay/visit	Not covered	Prior approval required
	Physician/surgeon fees	\$0 copay/visit	Not covered	Prior approval required
<b>If you need immediate medical attention</b>	Emergency room services	\$50 copay/visit	\$50 copay/visit	-----None-----
	Emergency medical transportation	\$0 co-pay	\$0 co-pay	-----None-----
	Urgent care	Preferred: \$0 co-pay/visit Participating: \$10 co-pay/visit	Not covered	-----None-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$100 Copayment per Continuous confinement	Not covered	Prior approval required
	Physician/surgeon fee	\$0 co-pay	Not covered	-----None-----
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Preferred: \$0 co-pay/visit Participating: \$10 co-pay/visit	Not covered	Prior approval may be required
	Mental/Behavioral health inpatient services	\$100 Copayment per Continuous confinement	Not covered	Prior approval required
	Substance use disorder outpatient services	Preferred: \$0 co-pay/visit Participating: \$10 co-pay/visit	Not covered	Prior approval may be required
	Substance use disorder inpatient services	\$100 Copayment per Continuous confinement	Not covered	Prior approval required
<b>If you are pregnant</b>	Prenatal and postnatal care	Preferred: \$0 co-pay/visit Participating: \$10 co-pay/visit	Not covered	-----None-----

Questions: Call 1-800-447-8255 or visit us at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc) or call 1-800-447-8255 to request a copy.



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
	Delivery and all inpatient services	\$100 Copayment per Continuous confinement	Not covered	Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Prior approval required.
<b>If you need help recovering or have other special health needs</b>	Home health care	\$0 co-pay/visit	Not covered	Coverage limited to 200 visits/year. Prior approval required.
	Rehabilitation services	Preferred: \$0 co-pay/visit Participating: \$10 co-pay/visit	Not covered	Coverage limited to 90 visits per plan year. Prior approval required.
	Habilitation services	Preferred: \$0 co-pay/visit Participating: \$10 co-pay/visit	Not covered	
	Skilled nursing care	\$0 co-pay	Not covered	Unlimited days per plan year. Prior approval required.
	Durable medical equipment	Not Covered	Not covered	-----None-----
	Hospice service	\$0 co-pay	Not covered	Coverage limited to 210 days. Prior approval required.
<b>If your child needs dental or eye care</b>	Eye exam	Preferred: \$0 co-pay/visit Participating: \$10 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	

Questions: Call 1-800-447-8255 or visit us at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc) or call 1-800-447-8255 to request a copy.



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 excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental care
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside of the U.S
- Private-duty nursing
- Routine foot care

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
- Chiropractic care
- Infertility Treatment
- Private-duty Nursing
- Routine eye care
- Weight loss programs

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 1-800-447-8255. 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."

Questions: Call 1-800-447-8255 or visit us at www.emblemhealth.com/sbc.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.emblemhealth.com/sbc or call 1-800-447-8255 to request a copy.



### 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</p> <p>All other grievances should be mailed to: EmblemHealth-Grievance Unit P.O. Box 1701 New York, New York 10023-9476</p> <p>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</p> <p>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 (<a href="http://www.dfs.ny.gov/">www.dfs.ny.gov/</a>), or The EmblemHealth Medical/Utilization Review Department at 1-877-482-3625</p>
---	--

### 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 1-800-447-8255.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-447-8255.
- Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-447-8255.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-447-8255

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

**Questions:** Call 1-800-447-8255 or visit us at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc) or call 1-800-447-8255 to request a copy.

## 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 \$5,340
- Patient pays \$2,200

**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
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$0
Co-pays	\$2,050
Co-insurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,200</b>

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: 1-800-447-8255.

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

- Amount owed to providers: \$5,400
- Plan pays \$4,205
- Patient pays \$1,195

**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
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$0
Co-pays	\$1,145
Co-insurance	\$0
Limits or exclusions	\$50
<b>Total</b>	<b>\$1,195</b>

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: 1-800-447-8255

**Questions:** Call 1-800-447-8255 or visit us at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc) or call 1-800-447-8255 to request a copy.



## 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.

**Questions:** Call 1-800-447-8255 or visit us at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc) or call 1-800-447-8255 to request a copy.