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 or call 1-800-624-2414 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>In network medical and hospital services are not subject to a deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For in network providers $3,300 Individual / $6,600 Family.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, penalties, balanced-bill charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.EmblemHealth.com">www.EmblemHealth.com</a> or call 1-800-447-8255 for a list of participating providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes, written approval is required to see a specialist.</td>
<td>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.</td>
</tr>
</tbody>
</table>
**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 Participating: $10 co-pay visit | Not covered | -----None-----
| Specialist visit | Preferred: $0 co-pay visit Participating: $10 co-pay visit | Not covered | Referral required
| Preventive care/screening/immunization | No charge | Not covered | Applies to Well Child Visits; Adult Annual Physical Exams; Well Woman Exams; Bone Density Testing.
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If you have a test | Diagnostic test (x-ray, blood work) | Preferred: $0 co-pay visit Participating: $10 co-pay visit | Not covered | Referral required for Specialist Office and Outpatient Hospital.
| Imaging (CT/PET scans, MRIs) | Preferred: $0 co-pay visit Participating: $10 co-pay visit | Not covered | Referral required
---
If you need drugs to treat your illness or condition | Generic drugs (Tier 1) | Retail: $5 co-pay/30 day supply 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 Mail Order: $22.50 co-pay/90 day supply | Not covered | Tier 1 and Tier 2 drugs are covered.
| Non-preferred brand drugs (Tier 3) | Not Covered | Not covered | Tier 1 and Tier 2 drugs are covered.
| Specialty drugs (Tier 4) | Tier 1: $5 co-pay/30 day supply Tier 2: $15 co-pay/30 day supply | Not covered | Written referral required.
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If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | $50 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 visit | Not covered | -----None-----

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

Coverage Period: 07/01/2018 - 06/30/2019
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>Network Provider (You will pay the least): $100 per admission</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Preferred: $0 co-pay visit Participating: $10 co-pay visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$100 per admission</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$100 per admission</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient: $100 per admission Outpatient: Preferred: $0 co-pay visit Participating: $10 co-pay visit</td>
<td>Inpatient: $100 per admission Outpatient: Preferred: $0 co-pay visit Participating: $10 co-pay visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Inpatient: $100 per admission Outpatient: Preferred: $0 co-pay visit Participating: $10 co-pay visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Inpatient: $100 per admission Outpatient: Preferred: $0 co-pay visit Participating: $10 co-pay visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* 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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Children's eye exam</td>
<td>Preferred: $0 co-pay visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participating: $10 co-pay visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Frames: $80 allowance; Standard single, bifocal or</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>trifocal lenses: $35 co-pay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Most coverage provided outside the United States</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>

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 (Adult)                                   |

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.cccio.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 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

* For more information about limitations and exceptions, see the plan or policy document at www.emblemhealth.com/sbc.
For HMO Coverage
New York State Department of Health
By Phone: 1-800-206-8125
In writing:
New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1607
Albany, NY 12237
Email: managedcarecomplaint@health.ny.gov
Website: www.health.ny.gov

For Group Coverage:
U.S. Department of Labor
Employee Benefits Security Administration at 1-866-444-EBSA (3272)
Website: www.dol.gov/ebsa/healthreform

Consumer Assistance Program
New York State Consumer Assistance Program
By Phone: 1-888-614-5400
In writing:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Email: cha@cssny.org
Website: www.communityhealthadvocates.org

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, 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.

* For more information about limitations and exceptions, see the plan or policy document at www.emblemhealth.com/sbc.
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)

Total Example Cost: $12,800

In the example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Copayments</th>
<th>$320</th>
</tr>
</thead>
</table>

In the example, Joe would pay:

- Deductibles: $0
- Copayments: $780
- Co-insurance: $0

In the example, Mia would pay:

- Deductibles: $0
- Copayments: $130
- Co-insurance: $0

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact 1-800-318-2596.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?” row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.
GETTING HELP IN A LANGUAGE OTHER THAN ENGLISH

Getting Help in a Language Other than English

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。如果您需要協助來理解文件內容，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)

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.

עִדְישָה (Yiddish)
מעלדונג גערופן נומבער טעלעפון דעם רעדט איר אויב. דאקומענט ויכטיגע איז "customer service" קארטל אייער אויפט קאראלי

Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.
Coverage Period: 07/01/2018 - 06/30/2019
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.