### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers</th>
<th>Why this Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0, in network providers, $250 Individual / $500 Family out of network providers.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</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. All covered out of network services, except emergency care, are 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 $6,600 Individual / $13,200 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>
All **coppayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<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 visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least): $15 co-pay visit</td>
<td>Out-of-Network Provider (You will pay the most): After Plan deductible is met, 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge</td>
<td>After Plan deductible is met, 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>After Plan deductible is met, 30% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td>No charge</td>
<td>After Plan deductible is met, 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>After Plan deductible is met, 30% coinsurance</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs (Tier 1)</td>
<td>Retail: $10 co-pay/30 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>Retail: $15 co-pay/30 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>Retail: $30 co-pay/30 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Specialty drugs</strong></td>
<td>Tier 1: $10 co-pay/30 day supply Tier 2: $15 co-pay/30 day supply Tier 3: $30 co-pay/30 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>After Plan deductible is met, 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>After Plan deductible is met, 30% coinsurance</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).
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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room care</td>
<td>$50 co-pay</td>
<td>$50 co-pay</td>
<td>Applies to facility charge, waived if admitted.</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
<td>----None------</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$15 co-pay visit</td>
<td>After Plan deductible is met, 30% coinsurance</td>
<td>Applies to facility charge.</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>After Plan deductible is met, 30% coinsurance</td>
<td>Preauthorization required</td>
</tr>
<tr>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>After Plan deductible is met, 30% coinsurance</td>
<td>----None------</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td>$15 co-pay visit</td>
<td>After Plan deductible is met, 30% coinsurance</td>
<td>Unlimited visits. For Substance Abuse care, up to 20 visits per plan year may be used for family counseling</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>No charge</td>
<td>After Plan deductible is met, 30% coinsurance</td>
<td>Preauthorization required. However, Preauthorization is not required for emergency admissions.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>No charge</td>
<td>After Plan deductible is met, 30% coinsurance</td>
<td>----None------</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>After Plan deductible is met, 30% coinsurance</td>
<td>----None------</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>After Plan deductible is met, 30% coinsurance</td>
<td>Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Preauthorization required</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at <www.emblemhealth.com/sbc>.
<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>If you need help recovering or have other special health needs</td>
<td><strong>Home health care</strong></td>
<td>$15 co-pay visit</td>
<td>After Plan deductible is met, 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>Inpatient: No charge Outpatient: $15 co-pay visit</td>
<td>After Plan deductible is met, 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>Inpatient: No charge Outpatient: $15 co-pay visit</td>
<td>After Plan deductible is met, 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td><strong>Children’s eye exam</strong></td>
<td>$15 co-pay</td>
<td>After Plan deductible is met, 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s glasses</strong></td>
<td>Frames: $80 allowance; Standard single, bifocal or trifocal lenses: $35 co-pay</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s dental check-up</strong></td>
<td>$5 co-pay/visit</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).
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>
</table>
| • 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.)

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
</table>
| • 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.ccio.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

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# 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

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

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### 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):** Dine'ehgo shika at'ohwol ninisingo, kwijijgo holne’ 1-800-624-2414

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Peg would pay</th>
<th>Deductibles</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Copayments</td>
<td>$340</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

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:**
- Deductibles: $0
- Copayments: $340
- Coinsurance: $0
- The total Peg would pay is: $400

### Managing Joe’s type 2 diabetes
(a year of routine in-network care of a well-controlled condition)

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Joe would pay</th>
<th>Deductibles</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Copayments</td>
<td>$1,065</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

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**: $7,400

**In the example, Joe would pay:**
- Deductibles: $0
- Copayments: $1,065
- Coinsurance: $0
- The total Joe would pay is: $1,120

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Mia would pay</th>
<th>Deductibles</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Copayments</td>
<td>$120</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Co-insurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

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**: $1,900

**In the example, Mia would pay:**
- Deductibles: $0
- Copayments: $120
- Co-insurance: $0
- The total Mia would pay is: $120

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)

中文 (Traditional Chinese)
注意: 我们免费提供相关的语言协助服务。请致电 1-877-411-3625 (TTY/TDD: 711)。

Русский (Russian)

Kreyòl Ayisyen (Haitian Creole)

한국어 (Korean)

Italiano (Italian)

אידיש (Yiddish)

বাংলা (Bengali)
মনোনীত ভিত্তি: ভাষা সহযোগ পদ্ধতিগুলি অপারেটিং জার ব্যাপারে উপরিব্যাপ্ত আরো। 1-877-411-3625 (TTY/TDD: 711) মূর্তি ফোন করুন।

Polski (Polish)


ΠΡΟΣΟΧΗ: Διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε το 1-877-411-3625 (για άτομα με προβλήματα ακοής (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 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.

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