### Important Questions

| What is the overall deductible? | In-Network: $4,700 individual / $9,400 family. | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| Are there services covered before you meet your deductible? | Yes. Preventive care, telemedicine are covered before you meet your deductible. | 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 [https://www.healthcare.gov/coverage/#preventive-care-benefits/](https://www.healthcare.gov/coverage/#preventive-care-benefits/). |
| Are there other deductibles for specific services? | There are no other specific deductibles. | You don’t have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | For participating providers $8,700 individual / $17,400 family | 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, the overall family out-of-pocket limit must be met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing 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. |
| Will you pay less if you use a network provider? | Yes. See [www.EmblemHealth.com](http://www.EmblemHealth.com) or call 1-800-447-8255 for a list of participating providers. | 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 a non-participating 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. |
| Do you need a referral to see a specialist? | Yes | 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. |
All **copayment** 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>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</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>$50 <strong>copayment</strong> after deductible</td>
<td>Not Covered</td>
<td>First 3 visits (any combination of PCP, Specialist, ABA, MH/SUD) $30 not subject to <strong>deductible</strong>.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$75 <strong>copayment</strong> after deductible</td>
<td>Not Covered</td>
<td>Referral required. First 3 visits (any combination of PCP, Specialist, ABA, MH/SUD) $75 not subject to <strong>deductible</strong>.</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Xray: $75 <strong>copayment</strong> after deductible, Lab: $50 <strong>copayment</strong> after deductible</td>
<td>Not Covered</td>
<td><strong>Preauthorization</strong> may be required.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$175 <strong>copayment</strong> after deductible</td>
<td>Not Covered</td>
<td><strong>Preauthorization</strong> required.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at www.emblemhealth.com.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs (Tier 1)</td>
<td>$10 <strong>copayment</strong> after deductible (retail); $25 <strong>copayment</strong> after deductible (mail order)</td>
<td>Not Covered (retail); Not Covered (mail order)</td>
<td>Preauthorization is not required for a covered prescription drug used to treat a substance use disorder, including a prescription drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. Your cost may be higher if you select a brand name drug when a generic medicine is available. This plan has a Preferred Pharmacy Network which excludes CVS.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.EmblemHealth.com">www.EmblemHealth.com</a></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>$35 <strong>copayment</strong> after deductible (retail); $87.50 <strong>copayment</strong> after deductible (mail order)</td>
<td>Not Covered (retail); Not Covered (mail order)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>$70 <strong>copayment</strong> after deductible (retail); $175 <strong>copayment</strong> after deductible (mail order)</td>
<td>Not Covered (retail); Not Covered (mail order)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (Tier 4)</td>
<td>After deductible: Tier 1: $10 copay/30 day supply Tier 2: $35 copay/30 day supply Tier 3: $70 copay/30 day supply (specialty retail only)</td>
<td>Not Covered (specialty retail only)</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$150 <strong>copayment</strong> after deductible</td>
<td>Not Covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$150 <strong>copayment</strong> after deductible</td>
<td>Not Covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$500 <strong>copayment</strong> after deductible</td>
<td>$500 <strong>copayment</strong> after deductible</td>
<td>Waived if admitted to Hospital.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$300 <strong>copayment</strong> after deductible</td>
<td>$300 <strong>copayment</strong> after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$75 <strong>copayment</strong> after deductible</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$1,500 <strong>copayment</strong> after deductible, per admission</td>
<td>Not Covered</td>
<td>Preauthorization required, except for emergency admissions.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$150 <strong>copayment</strong> after deductible</td>
<td>Not Covered</td>
<td>Preauthorization required.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.emblemhealth.com](http://www.emblemhealth.com).
<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 mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Participating Provider (You will pay the least)</td>
<td>Non-Participating Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Office Visits: $50 copayment after deductible</td>
<td>Not Covered</td>
<td>First 3 visits (any combination of PCP, Specialist, ABA, MH/SUD) $50 not subject to deductible. Unlimited visits. For Substance Abuse care, up to twenty (20) visits per plan year may be used for family counseling.</td>
</tr>
<tr>
<td></td>
<td>All Other Outpatient Services: $50 copayment after deductible</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$1,500 copayment after deductible, per admission</td>
<td>Preauthorization required, except for emergency admissions.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No Charge</td>
<td>Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA will use the cost sharing for the appropriate service.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>$150 copayment after deductible</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$1,500 copayment after deductible, per admission</td>
<td>Limited to forty-eight (48) hours for natural delivery and ninety-six (96) hours for caesarean delivery. One (1) home care visit covered in full if discharged early. Preauthorization required.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at www.emblemhealth.com.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home health care</td>
<td>$50 copayment after deductible</td>
<td>Not Covered</td>
<td>Forty (40) visits per plan year. Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Inpatient: $1,500 copayment after deductible, per admission</td>
<td>Not Covered</td>
<td>Inpatient: Sixty (60) days per condition/per plan year, combined therapies. Outpatient: Sixty (60) visits per condition/per plan year, combined therapies. Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Inpatient: $1,500 copayment after deductible, per admission</td>
<td>Not Covered</td>
<td>Inpatient: Sixty (60) days per condition/per plan year, combined therapies. Outpatient: Sixty (60) visits per condition/per plan year, combined therapies. Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$1,500 copayment after deductible, per admission</td>
<td>Not Covered</td>
<td>200 days per plan year. Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>50% coinsurance after deductible</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>Inpatient: $1,500 copayment after deductible, per admission</td>
<td>Not Covered</td>
<td>210 days per plan year. Five (5) visits for family bereavement counseling. Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Children's eye exam</td>
<td>$50 copayment after deductible</td>
<td>Not Covered</td>
<td>One (1) exam per twelve (12) month period.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>50% coinsurance after deductible</td>
<td>Not Covered</td>
<td>One (1) prescribed lenses and frames per twelve (12)-month period.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>$50 copayment after deductible</td>
<td>Not Covered</td>
<td>One (1) dental exam &amp; cleaning per six (6)-month period. Full mouth x-rays or panoramic x-rays.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
<td>• Long-term care</td>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Cosmetic Surgery</td>
<td>• Non-emergency care when traveling outside the U.S.</td>
<td>• Routine hearing tests</td>
</tr>
<tr>
<td>• Dental Care (Adult)</td>
<td>• Private-duty nursing</td>
<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.)

<table>
<thead>
<tr>
<th>Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Abortion Services</td>
<td>• Chiropractic care</td>
<td>• Infertility treatment (Prior Approval required)</td>
</tr>
<tr>
<td>• Bariatric Surgery (Prior Approval required)</td>
<td>• Hearing aids (Prior Approval required)</td>
<td>• Routine eye care</td>
</tr>
<tr>
<td>• Routine foot care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine hearing tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Weight loss programs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**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)

**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 rights, 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)

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**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)

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

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

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Coverage Meet the Minimum Value Standard? 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 1-888-447-8255
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-447-8255
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-447-8255
Navajo (Dine): Dinek’eihgo shika at’ohwol ninisingo, kwijjigo holne’ 1-888-447-8255

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

* For more information about limitations and exceptions, see the plan or policy document at www.emblemhealth.com.
About these Coverage Examples

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: $4700
- Specialist copayment: $75
- Hospital (facility) copayment: $1500
- Other copayment: $0

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: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
<th>Limits or exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$4,700</td>
<td>$1,800</td>
<td>$0</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Peg would pay is: $6,560

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

- The plan’s overall deductible: $4700
- Specialist copayment: $75
- Hospital (facility) copayment: $1500
- Other copayment: $0

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: $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
<th>Limits or exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$4,700</td>
<td>$100</td>
<td>$20</td>
<td>$20</td>
</tr>
</tbody>
</table>

The total Joe would pay is: $4,840

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

- The plan’s overall deductible: $4700
- Specialist copayment: $75
- Hospital (facility) copayment: $1500
- Other copayment: $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)

Total Example Cost: $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
<th>Limits or exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,800</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

The total Mia would pay is: $2,800

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: 1-800-390-3522.

*Note: This plan may have 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.
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)

Kreyòl Ayisyen (Haitian Creole)

한국어 (Korean)

Italiano (Italian)

אידיש (Yiddish)

বাংলা (Bengali)
মন্তব্য করার জন্য উপলক্ষে আপনার জন্য বিনামূল্যে উপলব্ধ আছে। 1-877-411-3625 (TTY/TDD: 711) নম্বরে ফোন করুন।

Polski (Polish)

العربية (Arabic)
يُرجى الاتصال: توفر لك خدمات المساعدة اللغوية مجانًا، اتصل على الرقم 1-877-411-3625 أو (TTY/TDD: 711).

Français (French)

اردو (Urdu)
توجہ دینے، آپ کی اصطلاحیات کے متعلق ایک خدمات، مفت استعمال کے ساتھ ہے 1-877-411-3625 (TTY/TDD: 711).

Tagalog (Tagalog)

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)
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.