### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why this Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$200 individual/$500 family for out-of-network only.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes</td>
<td>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.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>No</td>
<td>Not applicable because there’s no out-of-pocket limit on your expenses.</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>Is there an overall annual limit on what the plan pays?</td>
<td>No</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.EmblemHealth.com">www.EmblemHealth.com</a> or call 1-877-842-3625 for a list of participating providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes</td>
<td>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.</td>
</tr>
</tbody>
</table>
**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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 co-pay/visit</td>
<td>0% co-insurance</td>
<td>----None----</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 co-pay/visit</td>
<td>0% co-insurance</td>
<td>Does not apply to all specialists.</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$15 co-pay/visit</td>
<td>0% co-insurance</td>
<td>----None----</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>$0 co-pay/visit</td>
<td>0% co-insurance</td>
<td>For annual physicals, you must be 45 years old or older. Only Influenza and Pneumonia vaccines are covered.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$15 co-pay/visit</td>
<td>0% co-insurance</td>
<td>----None----</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$15 co-pay/visit</td>
<td>0% co-insurance</td>
<td>Pre-certification required.</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage:

### What this Plan Covers & What it Costs

**Coverage for:** Individual/Family  
**Plan Type:** PPO  
**Coverage Period:** 07/01/2015 - 06/30/2016

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>


### If you have outpatient surgery

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Please check with your employer.</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>Covered</td>
<td>0% co-insurance</td>
<td>----None----</td>
</tr>
</tbody>
</table>

### If you need immediate medical attention

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>----None----</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>Not covered</td>
<td>20% co-insurance</td>
<td>----None----</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$15 co-pay/visit</td>
<td>0% co-insurance</td>
<td>----None----</td>
</tr>
</tbody>
</table>

### If you have a hospital stay

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>Not covered</td>
<td>Not covered</td>
<td>----None----</td>
</tr>
<tr>
<td>Physician/surgeon fee</td>
<td>Covered</td>
<td>0% co-insurance</td>
<td>----None----</td>
</tr>
</tbody>
</table>

### If you have mental health, behavioral health, or substance abuse needs

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental/Behavioral health outpatient services</td>
<td>$15 co-pay/visit</td>
<td>Subject to New York City non-participating benefit $200/$500 calendar year deductible</td>
<td>No lifetime maximum</td>
</tr>
<tr>
<td>Mental/Behavioral health inpatient services</td>
<td>$300 co-pay per admission</td>
<td>$500 co-pay per admission/$1,250 maximum per calendar year</td>
<td>20% to max of $2,000 per person per calendar year</td>
</tr>
<tr>
<td>Substance use disorder outpatient services</td>
<td>$15 co-pay/visit</td>
<td>Subject to New York City non-participating benefit $200/$500 calendar year deductible</td>
<td>No lifetime maximum</td>
</tr>
<tr>
<td>Substance use disorder inpatient services</td>
<td>$300 co-pay per admission</td>
<td>$500 co-pay per admission/$1,250 maximum per calendar year</td>
<td>----None----</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-624-2414 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 1-800-624-2414 to request a copy.
### Summary of Benefits and Coverage
What this Plan Covers & What it Costs

#### Coverage Period:
07/01/2015 - 06/30/2016

#### Plan Type:
PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
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<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>0% co-insurance</td>
<td>Pre-certification required. Contact NYC Healthline at 1-800-521-9574.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>No charge</td>
<td>0% co-insurance</td>
<td>Pre-certification required. Contact NYC Healthline at 1-800-521-9574.</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>$50 deductible per episode; 20% co-insurance</td>
<td>200 visits per member per year. Pre-certification required.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15 co-pay</td>
<td>0% co-insurance</td>
<td>16 visits per calendar year</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$15 co-pay</td>
<td>0% co-insurance</td>
<td>----None----</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Not covered</td>
<td>Not covered</td>
<td>----None----</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>$100 deductible</td>
<td>$100 deductible; 50% of usual and customary charge</td>
<td>Pre-certification required on greater than $2,000 call NYC Healthline at 1-800-521-9574.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>Not covered</td>
<td>Not covered</td>
<td>----None----</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>----None----</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>----None----</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>----None----</td>
</tr>
</tbody>
</table>

#### 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
- Routine eye care
- Routine foot care
- Weight loss programs

**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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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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.

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.

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

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.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-624-2414.

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Coverage 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.

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Questions: Call 1-800-624-2414 or visit us at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).
If you aren't clear about any of the bolded 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 1-800-624-2414 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.