



This is only a summary. If you want more detail about your coverage, you can get the complete terms in the policy or plan document by calling 1-877-244-4466. Benefits may vary if you have other coverage, such as Medicare. You can get more information at www.emblemhealth.com or by calling 1-877-244-4466

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	No	You must pay all of the costs for these services up to the specific <u>deductible</u> before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Yes, for in-network providers \$6,350 individual / \$12,700 family for out of pocket maximum.	Premiums, penalties, balanced-bill charges and health care this plan doesn't cover.
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 www.EmblemHealth.com or call 1-877-244-4466 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See the NYSHIP benefit brochure for additional information about <u>excluded services</u> .

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- **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 participating **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 (plus you may be balance billed)	Limitations & Exceptions
If you visit a health care <u>provider’s</u> office or clinic	Primary care visit to treat an injury or illness	\$20 co-pay/visit	Not covered	---none---
	Specialist visit	\$20 co-pay/visit	Not covered	---none---
	Other practitioner office visit	Chiropractor: \$20 co-pay/visit	Not covered	---none---
	Preventive care/screening/immunization	No charge	Not covered	---none---
If you have a test	Diagnostic tests (blood work)	\$0 co-pay/test	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	\$20 co-pay/test	Not covered	---none---
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	---none---
	Preferred brand drugs	Not covered	Not covered	---none---
	Non-preferred brand drugs	Not covered	Not covered	---none---

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GHI HMO PLAN – NO PRESCRIPTION: NYSHIP

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 1/1/2014-12/31/2014

Coverage for: Self & Family | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
More information about prescription drug coverage is available at www.emblemhealth.com	Specialty drugs	Not covered	Not covered	---none---
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$75 co-pay/visit	Not covered	Prior approval required
	Physician/surgeon fees	No charge	Not covered	Prior approval required
If you need immediate medical attention	Emergency room services	\$50 co-pay/visit	\$100 co-pay/visit	---none---
	Emergency medical transportation	No charge	No charge	---none---
	Urgent care	\$35 co-pay/visit	Not covered	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 per continuous confinement	Not covered	Prior approval required
	Physician/surgeon fee	No charge	Not covered	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 co-pay/visit	Not covered	No visit limits for biologically-based mental illness and children with serious emotional disturbances. Prior approval required
	Mental/Behavioral health inpatient services	\$0 per continuous confinement	Not covered	No visit limits for biologically-based mental illness and children with serious emotional disturbances. Prior approval required
	Substance use disorder outpatient services	\$20 co-pay/visit	Not covered	Prior approval required
	Substance use disorder inpatient services	\$0 per continuous confinement	Not covered	Prior approval required
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	---none---

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
	Delivery and all inpatient services	\$0 per continuous confinement	Not covered	Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Prior approval required.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	---none---
	Rehabilitation services	Inpatient: \$0 per continuous confinement Outpatient: \$20 co-pay/visit	Not covered	Outpatient coverage limited to two months per condition.
	Habilitation services	Not covered	Not covered	---none---
	Skilled nursing care	No charge	Not covered	Prior approval required
	Durable medical equipment	No charge	Not covered	Prior approval required
	Hospice service	No charge	Not covered	Limited to 210 days
If your child needs dental or eye care	Eye exam	\$20 copay	Not covered	---none---
	Glasses	Not covered	Not covered	---none---
	Dental check-up	Not covered	Not covered	---none---

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check this plan's GHI HMO brochure for other excluded services.)

- | | | |
|--------------------|------------------|------------------------------------------------------|
| • Cosmetic surgery | • Dental care | • Non-emergency care when traveling outside the U.S. |
| | • Hearing Aids | • Weight loss programs |
| | • Long-term care | |

Other Covered Services (This isn't a complete list. Check this plan's NYSHIP brochure for other covered services and your costs for these services.)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will 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. An individual policy may also provide different benefits than you had 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, see the NYSHIP Plan brochure, contact your HR office/retirement system, contact your plan at 1-877-244-4466 or visit www.emblemhealth.com

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Your Appeal 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.

By phone: 1-877-244-4466

In writing: EmblemHealth

PO Box 2844

New York, NY 10116-284

In person: EmblemHealth

Customer Service Interview Unit

55 Water Street, 1st Floor

New York, NY 10041-8190

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 1-877-244-4466.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1800-447-8255.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-244-4466.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-244-4466. *—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————*

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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 \$** 7230
- **Patient pays \$** 310

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
Copays	\$160
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$310

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

- **Amount owed to providers:** \$5,400
- **Plan pays \$** 2020
- **Patient pays \$** 3380

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
Copays	\$200
Coinsurance	\$250
Limits or exclusions	\$2930
Total	\$3380

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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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

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