NYC EMPLOYEES PPO PLAN

Coverage for: Individual + Family | **Plan Type:** PPO

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, visit **www.nyceppo.com** or call **1-212-501-4444**. 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.healthcare.gov/glossary** or call **1-212-501-4444** to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0 person / $0 family in-network $200 person / $500 family out-of-network	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 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.
Are there services covered before you meet your deductible?	Yes. Preventive care services 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/**.
Are there other deductibles for specific services?	Yes. See durable medical equipment and private-duty nursing.	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.
What is the out-of-pocket limit for this plan?	$200 person participating / $2,000 person out-of-network annual coinsurance out-of-pocket maximum $1,250 person out-of-network annual copay out-of-pocket maximum $7,150 person / $14,300 family in-network Unlimited out-of-network annual total out-of-pocket maximum	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.
What is not included in the out-of-pocket limit?	Penalties, 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.nyceppo.com** or call **1-212-501-4444** for a list of network 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 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.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
		Preferred	Participating	Out-of-network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$15 copay per visit	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	None
	Specialist visit	No charge	$30 copay per visit		None
	Preventive care / screening / immunization	No charge	No charge		You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	$20 copay per visit for x-ray and $20 copay per visit for blood work	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	None
	Imaging (CT / PET scans, MRIs)	$25 copay per visit H+H; $50 copay per visit	$100 copay per visit		Preauthorization is required for certain Imaging services.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
		Preferred	Participating	Out-of-network	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at **www.emblemhealth.com**.	Base benefit – ACA mandated and diabetic	Not applicable	Insulin: $0; Diabetic supply only: generic $5, brand $15; Opioid withdrawal medication: Tier 1 20% coinsurance w/ $5 min charge, Tier 2 40% coinsurance w/ $25 min charge, Tier 3 50% coinsurance w/ $40 min charge	Not covered	ACA prescription drugs covered at $0. Cost share for each prescription up to 30-day supply (up to 90-day supply for home delivery). Cost share will only apply to the total out-of-pocket maximum. Prescriptions will not be filled at retail after 2 fills. PICA Specialty prescription drugs not covered. Non-PICA specialty drugs must be dispensed by the specialty pharmacy. Rider coverage only available to those who have selected the optional prescription rider.
	Optional drug rider generic drugs (Tier 1)	Not applicable	Retail: 20% coinsurance with min charge of $5 or actual cost, if less; Home delivery: $12.50	Not covered	
	Optional drug rider Preferred Brand drugs (Tier 2)	Not applicable	Retail: 40% coinsurance with min charge of $25 or actual cost, if less; Home delivery: $50	Not covered	
	Optional drug rider Nonpreferred Brand drugs (Tier 3)	Not applicable	Retail: 50% coinsurance with min charge of $40 or actual cost, if less; Home delivery: $75	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	$500 copay per occurrence; 20% coinsurance; Deductible waived; You pay the difference between the plan allowance and the provider's fee.	Preauthorization is required for certain surgeries. See page 1 for out-of-pocket limits.
	Physician / surgeon fees	No charge	No charge	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	
If you need immediate medical attention	Emergency room care	$150 copay per visit	$150 copay per visit	$150 copay per visit; Deductible waived	Copay waived if admitted within 24 hours
	Emergency medical transportation	No charge air and ground; Not covered nonemergency ground	No charge air and ground; Not covered nonemergency ground	No charge; Deductible waived air and ground; Not covered nonemergency ground	Preauthorization is required for nonemergency air services.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
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	Urgent care	$25 copay per visit H+H; $50 copay per visit Preferred	$50 copay per visit	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	$100 copay per visit CityMD and ProHealth for downstate New York service area
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	$300 copay per admission not to exceed $750 per calendar year combined with skilled nursing care	$500 copay per admission; 20% coinsurance; Deductible waived; You pay the difference between the plan allowance and the provider's fee.	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250 per day up to a $500 maximum of the total cost of the service for out-of-network only. See page 1 for out-of-pocket limits.
	Physician / surgeon fees	No charge	No charge	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$15 copay per office visit; No charge other outpatient services	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	Preauthorization is required for partial hospitalization.
	Inpatient services	No charge	$300 copay per admission not to exceed $750 per calendar year combined with skilled nursing care; No charge physician	$500 copay per admission; 20% coinsurance; Deductible waived; You pay the difference between the plan allowance and the provider's fee.	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250 per day up to a $500 maximum of the total cost of the service for out-of-network only. See page 1 for out-of-pocket limits.
If you are pregnant	Office visits	No charge	No charge	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). See page 1 for out-of-pocket limits.
	Childbirth / delivery professional services	No charge	No charge		

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
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	Childbirth / delivery facility services	No charge	$300 copay per admission not to exceed $750 per calendar year	$500 copay per admission; 20% coinsurance; Deductible waived; You pay the difference between the plan allowance and the provider's fee.	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	$50 copay per episode; 20% coinsurance; Deductible waived; You pay the difference between the plan allowance and the provider's fee.	200 maximum visits per calendar year preferred and participating; 40 maximum visits per calendar year out-of-network; Preauthorization for certain home health visits is required.
	Rehabilitation services	No charge	$20 copay per visit	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	Preauthorization is required after 25 combined visits occupational therapy / physical therapy. Preauthorization is required after 25 visits speech therapy. Habilitation services for learning disabilities are covered to age 3; Not covered from age 3.
	Habilitation services	No charge	$20 copay per visit		
	Skilled nursing care	No charge	$300 copay per admission not to exceed $750 per calendar year combined with inpatient hospital	$500 copay per admission; 20% coinsurance; Deductible waived; You pay the difference between the plan allowance and the provider's fee.	90 maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250 per day up to a $500 maximum of the total cost of the service for out-of-network only. See page 1 for out-of-pocket limits.
	Durable medical equipment (DME)	$100 deductible, combined w/ DME and prosthetics	$100 deductible, combined w/ DME and prosthetics	$100 deductible, combined w/ DME and prosthetics. You pay the difference between the plan allowance and the provider's fee.	$100 deductible per calendar year; Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases.
	Hospice service	No charge	No charge	Deductible waived; You pay the difference between the plan allowance and the provider's fee.	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
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If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

Excluded Services and Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture.
- Cosmetic surgery.
- Dental care.
- Hearing aids.
- Long-term care.
- Preauthorization - You may have to pay for all or a portion of any test, equipment, service, or procedure that is not preauthorized. Contact us to find out what must be preauthorized and whether preauthorization has been given.
- Routine eye care (adult).
- 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.)

- Bariatric surgery (bariatric program included, preauthorization required).
- Chiropractic care.
- Infertility treatment (preauthorization required).
- Nonemergency care when traveling outside the U.S.
- Private-duty nursing (outpatient care; $250 deductible per calendar year, preauthorization required).

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 U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at **1-877-267-2323** x61565 or **www.cciio.cms.gov**. 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 rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at **www.HealthCare.gov** and **http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/**.

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 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 **1-212-501-4444**.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 **1-212-501-4444**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-212-501-4444**.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff **1-212-501-4444**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-212-501-4444**.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni **1-212-501-4444**.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye **1-212-501-4444**.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang **1-212-501-4444**.

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

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 preferred pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal 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:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

Managing Joe's Type 2 Diabetes
(a year of routine preferred care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	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:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$90**

Mia's Simple Fracture
(preferred emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

The plan would be responsible for the other costs of these EXAMPLE covered services.