


**NYC EMPLOYEES PPO PLAN**



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](http://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](http://www.healthcare.gov/glossary) or call 1-212-501-4444 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <a href="#">deductible</a> ?	\$0 person / \$0 family in-network \$200 person / \$500 family out-of-network	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. See <a href="#">durable medical equipment</a> and private-duty nursing.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$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 <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Penalties, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.nyceppo.com">www.nyceppo.com</a> or call 1-212-501-4444 for a list of <a href="#">network providers</a> . **While <a href="#">providers</a> are responsible for obtaining all prior authorizations, it is the member's responsibility to confirm with their <a href="#">provider</a> that all authorizations have been obtained before treatment.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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 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 <a href="#">provider's</a> 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
	<a href="#">Specialist</a> visit	No charge	\$30 copay per visit		None
	<a href="#">Preventive care / screening / immunization</a>	No charge	No charge		You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (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		<a href="#">Preauthorization</a> 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	
<p><b>If you need drugs to treat your illness or condition.</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.emblemhealth.com">www.emblemhealth.com</a>.</p>	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	<p>ACA prescription drugs covered at \$0.</p> <p>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.</p>
	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	<p>Prescriptions will not be filled at retail after 2 fills.</p> <p><a href="#">PICA</a> Specialty prescription drugs not covered. Non-PICA specialty drugs must be dispensed by the specialty pharmacy.</p>
	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	<p>Rider coverage only available to those who have selected the optional prescription rider.</p>
	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	
<p><b>If you have outpatient surgery</b></p>	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.	<p><a href="#">Preauthorization</a> is required for certain surgeries.</p>
	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.	<p>See page 1 for <a href="#">out-of-pocket limits</a>.</p>

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 immediate medical attention	<a href="#">Emergency room care</a>	\$150 copay per visit	\$150 copay per visit	\$150 copay per visit; Deductible waived	Copay waived if admitted within 24 hours
	<a href="#">Emergency medical transportation</a>	No charge air and ground; Not covered nonemergency ground	No charge air and ground; Not covered nonemergency ground	Deductible waived air and ground; Not covered nonemergency ground; Emergency ground you pay the difference between the plan allowance and the provider's fee.	<a href="#">Preauthorization</a> is required for nonemergency air services.
	<a href="#">Urgent care</a>	\$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.	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , 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 <a href="#">out-of-pocket limits</a> & <a href="#">Preauthorization</a> .
	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.	<a href="#">Preauthorization</a> is required for partial <a href="#">hospitalization</a> .
	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.	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , 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. Penalty does not apply to Mental Health or Substance Use Disorder admissions for patients under age 18 for the first 14 days of the admission. See page 1 for <a href="#">out-of-pocket limits</a> & <a href="#">Preauthorization</a> .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
		Preferred	Participating	Out-of-network	
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.	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">deductible</a> , <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).  See page 1 for <a href="#">out-of-pocket limits</a> .
	Childbirth / delivery professional services	No charge	No charge		
	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	<a href="#">Home health care</a>	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; <a href="#">Preauthorization</a> for certain home health visits is required.
	<a href="#">Rehabilitation services</a>	No charge	\$20 copay per visit	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	<a href="#">Preauthorization</a> is required after 25 combined visits occupational therapy / physical therapy. <a href="#">Preauthorization</a> is required after 25 visits speech therapy. Habilitation services for learning disabilities are covered to age 3; Not covered from age 3.
	<a href="#">Habilitation services</a>	No charge	\$20 copay per visit		
	<a href="#">Skilled nursing care</a>	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; <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , 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 <a href="#">out-of-pocket limits</a> & <a href="#">Preauthorization</a> .
	<a href="#">Durable medical equipment (DME)</a>	\$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; <a href="#">Preauthorization</a> is required for DME in excess of \$500 for rentals or \$1,500 for purchases.
	<a href="#">Hospice service</a>	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
		Preferred	Participating	Out-of-network	
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 <a href="#">Plan</a> Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture.</li> <li>• Cosmetic surgery.</li> <li>• Dental care.</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids.</li> <li>• Long-term care.</li> <li>• <a href="#">Preauthorization</a> - 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (adult).</li> <li>• Routine foot care.</li> <li>• Weight loss programs.</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Bariatric surgery (bariatric program included, preauthorization required).</li> <li>• Chiropractic care.</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment (preauthorization required).</li> <li>• Nonemergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing (outpatient care; \$250 deductible per calendar year, preauthorization required).</li> </ul>

**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](http://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](http://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](http://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, kwijigo holne' **1-212-501-4444**.

Pennsylvania Dutch (Deitsch): Fer Hilf griegie 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 allillis reel kapasal Falawasch au fafaingi tilifon ye **1-212-501-4444**.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'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:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$60</b>

**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:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$90</b>

**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:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$300</b>