

New York City Employee PPO (NYCE PPO) plan

This document is a high-level overview of plan benefits. Please see NYCE PPO SPD for full benefits and details.

| | | In-network | | Out-of-network |
|--|----------------------------------|--|--|--|
| <ul style="list-style-type: none"> All benefit maximums are per calendar year unless otherwise noted (1/1/26-12/31/26). Multiple copays can apply per visit. All benefits listed apply to medical, behavioral health and substance use. | | Preferred Available in the downstate New York area (EmblemHealth Bridge network). <ul style="list-style-type: none"> Advantage Care Physicians New York (ACPNY) NYC Health + Hospitals (H+H) Facility only: <ul style="list-style-type: none"> Memorial Sloan Kettering Cancer Center (MSK) Hospital for Special Surgery (HSS) | Participating Includes EmblemHealth Bridge network (downstate 13 counties), UnitedHealthcare national Choice Plus network and MAPFRE network in Puerto Rico. | Non-contracted providers You pay the difference between the plan allowance and the provider's fee. |
| Deductible per calendar year | | \$0 | | \$200 individual/\$500 family |
| Coinsurance out-of-pocket maximum per calendar year | | N/A | \$200 per person | \$2,000 per person* |
| Copay out-of-pocket maximum per calendar year (out-of-network) | | N/A | N/A | \$1,250 per person* |
| Total out-of-pocket maximum per calendar year Includes deductibles, copays, coinsurance and pharmacy. | | \$7,150 individual/\$14,300 family Once total out-of-pocket maximum is reached, member cost share will be waived for the remaining of the calendar year. | | No limit |
| Immediate care | | | | |
| Ambulance | Ground | No charge (Non-emergency ground ambulance not covered) | | You pay the difference between the plan allowance and the provider's fee. (Non-emergency ground ambulance not covered) |
| | Air | No charge | | |
| Emergency room | Facility | \$150 copay per visit (Copay waived if admitted within 24 hours) | | |
| | Emergency Physicians only | No charge | | |
| Teladoc Health Virtual office visit | | \$10 copay per visit | | N/A |
| Urgent care | | H+H: \$25 copay per visit \$50 copay per visit | \$50 copay per visit; \$100 copay per visit for CityMD and ProHealth in the downstate 13 counties only | After deductible is met, you pay the difference between the plan allowance and the provider's fee. |
| Medical office services (Multiple copays can apply per visit) | | | | |
| Primary care provider (PCP) Office visit | | No charge | \$15 copay per visit | After deductible is met, you pay the difference between the plan allowance and the provider's fee. |
| Specialist office visit | | No charge | \$30 copay per visit | |
| Walk in retail health clinic (Convenience care) | | No charge | \$15 copay per visit | |
| Labs (including allergy testing) Medical office and independent lab | | No charge | \$20 copay per visit | |
| X-ray Medical office and freestanding radiology center | | No charge | \$20 copay per visit | |
| Advanced imaging Medical office and freestanding radiology center | | H+H: \$25 copay per visit \$50 copay per visit | \$100 copay per visit | |
| Surgery Medical office | | No charge | No charge | |
| Allergy injections Medical office | | No charge | PCP: \$15 copay per visit Specialist: \$30 copay per visit | |

* Please see NYCE PPO SPD for full benefits, details and prior authorizations, or call **212-501-4444** (TTY: 711) from 8 a.m. to 6 p.m., Eastern Standard Time, Monday through Friday. Not all benefits apply to copay and coinsurance maximums.

| | | In-network | | Out-of-network |
|--|------------------|---|---|---|
| | | Preferred | Participating | Non-contracted providers |
| Inpatient services | | | | |
| Hospital facility fee (e.g., hospital room and all inpatient services) | | No charge | \$300 copay per admission up to \$750 per calendar year combined with skilled nursing care. | \$500 copay per admission up to \$1,250 per calendar year; 20% coinsurance up to \$2,000 per calendar year. You pay the difference between the plan allowance and the provider's fee. |
| 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. You must call 212-501-4444 (TTY: 711) for prior authorization. If you don't get prior authorization, 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. |
| Skilled nursing care | | No charge | \$300 copay per admission not to exceed \$750 per calendar year combined with inpatient hospital | \$500 copay per admission up to \$1,250 per calendar year; 20% coinsurance up to \$2,000 per calendar year. You pay the difference between the plan allowance and the provider's fee. |
| Outpatient services (Multiple copays can apply per visit) | | | | |
| Labs Outpatient hospital | Facility | No charge | \$20 copay per visit | After deductible is met, you pay the difference between the plan allowance and the provider's fee. |
| X-ray Outpatient hospital | Facility | No charge | \$20 copay per visit | |
| Advanced imaging Outpatient hospital | Facility | \$25 copay per visit (H+H) \$50 copay per visit (also includes Radnet and Zwanger in downstate NY) | \$100 copay per visit | |
| Surgery Outpatient hospital or ambulatory surgical center | Facility | No charge | 20% coinsurance — not to exceed the combined coinsurance out-of-pocket maximum of \$200 in a calendar year. | \$500 copay per visit — not to exceed the combined copay out-of-pocket maximum of \$1,250 in calendar year. 20% coinsurance — not to exceed the combined coinsurance out-of-pocket maximum of \$2,000 in calendar year. You pay the difference between the plan allowance and provider's fee. |
| | Physician | No charge | No charge | After deductible is met, you pay the difference between the plan allowance and the provider's fee. |

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| | In-network | | Out-of-network |
|--|---|----------------------|---|
| | Preferred | Participating | Non-contracted providers |
| Home care services | | | |
| Home health care | No charge | No charge | \$50 copay per episode 20% coinsurance — You pay the difference between the plan allowance and the provider's fee. Copay and coinsurance limits do not apply. |
| Private duty nursing | No charge | No charge | \$250 separate deductible per calendar year/20% coinsurance. After separate deductible is met, you pay the difference between the plan allowance and the provider's fee. Coinsurance limits do not apply. |
| Hospice Home and inpatient | No charge | No charge | After deductible is met, you pay the difference between the plan allowance and the provider's fee. |
| Equipment and supplies | | | |
| Durable medical equipment (DME) DME combined with prosthetics | \$100 separate deductible per calendar year | | \$100 separate deductible per calendar year. After separate deductible is met, you pay the difference between the plan allowance and the provider's fee. |
| Diabetic equipment and supplies | No charge | No charge | After deductible is met, you pay the difference between the plan allowance and the provider's fee. |
| Preventive care | | | |
| Preventive care | No charge | No charge | After deductible is met, you pay the difference between the plan allowance and the provider's fee. |
| Physical, occupational and speech therapies and chiropractic manipulation | | | |
| Physical, occupational and speech therapies | No charge | \$20 copay per visit | After deductible is met, you pay the difference between the plan allowance and the provider's fee. |
| Manipulations (Chiropractic) | No charge | \$15 copay per visit | |

Additional benefits and comments

- Infertility covered, 3 cycles per lifetime of in vitro fertilization maximum.
- Services in a country outside of the United States are covered at the out-of-network level of benefits.
- Pain management is excluded for out-of-network office and outpatient settings.
- Optum Transplant Resources Centers of Excellence are available at in-network participating benefits.
- Optum Bariatric Resources Services are available at in-network participating benefits.

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This is for informational purposes only. It is not medical advice and should not be substituted for regular consultation with your health care provider. If you have any concerns about your health, please contact your health care provider's office. Also, this information is not intended to imply that services or treatments described here are covered benefits under your plan. Please refer to your Summary of Benefits and Coverage, Summary Plan Description, or other plan documents for specific information about your benefits coverage.

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Base benefit drug coverage and optional rider

Prescription drugs provided through NYCE PPO

| | Retail | Home delivery |
|---|---|---|
| Base benefit — Affordable Care Act (ACA) mandated and diabetic | <p>90-day retail supply can be obtained at Walgreens/Duane Reade.</p> <p>Insulin: \$0</p> <p>Diabetic supply only: Generic \$5, brand \$15</p> <p>Opioid withdrawal medication:</p> <p>Tier 1 - 20% coinsurance with \$5 minimum charge.</p> <p>Tier 2 - 40% coinsurance with \$25 minimum charge.</p> <p>Tier 3 - 50% coinsurance with \$40 minimum charge.</p> <p>ACA prescription drugs covered at \$0</p> | <p>90-day mail supply can be obtained through Amazon Pharmacy.</p> <p>Home delivery: 90-day supply</p> <p>Diabetic supply only: Generic \$12.50, brand \$37.50</p> <p>Opioid withdrawal medication:</p> <p>Tier 1 - 20% coinsurance with \$5 minimum charge.</p> <p>Tier 2 - 40% coinsurance with \$25 minimum charge.</p> <p>Tier 3 - 50% coinsurance with \$40 minimum charge.</p> <p>ACA prescription drugs covered at \$0</p> |
| Optional drug rider generic drugs (Tier 1) | <p>90-day retail supply can be obtained at Walgreens/Duane Reade.</p> <p>30-day supply — 2 refills</p> <p>20% coinsurance with minimum charge of \$5 or actual cost, if less.</p> | <p>90-day mail supply can be obtained through Amazon Pharmacy.</p> <p>Home delivery: 90-day supply — \$12.50 copay</p> <p>Prescriptions will not be filled at retail after 2 refills.</p> |
| Optional drug rider preferred brand drugs (Tier 2)* | <p>90-day retail supply can be obtained at Walgreens/Duane Reade.</p> <p>30-day supply — 2 refills</p> <p>40% coinsurance with minimum charge of \$25 or actual cost, if less.</p> | <p>90-day mail supply can be obtained through Amazon Pharmacy.</p> <p>Home delivery: 90-day supply — \$50 copay</p> <p>Prescriptions will not be filled at retail after 2 refills.</p> |
| Optional drug rider non-preferred brand drugs (Tier 3)* | <p>90-day retail supply can be obtained at Walgreens/Duane Reade.</p> <p>30-day supply — 2 refills</p> <p>50% coinsurance with minimum charge of \$40 or actual cost, if less.</p> | <p>90-day mail supply can be obtained through Amazon Pharmacy.</p> <p>Home delivery: 90-day supply — \$75 copay</p> <p>Prescriptions will not be filled at retail after 2 refills.</p> |
| Specialty drugs* Must be dispensed by a specialty pharmacy | Covered (cost based on above categories). | You must call Prime Therapeutics (Rx) 833-998-5430 (TTY: 711) for prior authorization. |

Cost share will only apply to the total out-of-pocket maximum.

*Prior authorization is required for certain brand name medications. For specialty drugs only: Must be dispensed by a specialty pharmacy.

For the "PICA Program" specialty drugs, please refer to the Summary Plan Description (SPD).

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