EmblemHealth

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2024 to 12/31/2024

EmblemHealth : Millennium Platinum D

Coverage for: Individual + Family | Plan Type: HMO

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, call 1-800-447-8255. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-447-8255 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers
Are there services covered before you meet your deductible?	No	See the Common Medical Events chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers $2,000 individual / $4,000 family	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	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.EmblemHealth.com or call 1-800-447-8255 for a list of participating 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 a non-participating 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?	Yes	This plan will pay some or all of the costs to see a specialist for covered services, but only if you have a referral before you see the specialist.

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, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copayment	Not Covered	None
	Specialist visit	$35 copayment	Not Covered	Referral required.
	Preventive care / screening / immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Xray: $35 copayment , Lab: Performed in a PCP Office: $15 copayment Performed in a Specialist Office: $35 copayment	Not Covered	Preauthorization may be required.
	Imaging (CT/PET scans, MRIs)	$35 copayment	Not Covered	Preauthorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.EmblemHealth.com	Generic drugs (Tier 1)	$10 copayment (retail); $25 copayment (mail order)	Not Covered (retail); Not Covered (mail order)	Preauthorization is not required for a covered prescription drug used to treat a substance use disorder, including a prescription drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. Your cost may be higher if you select a brand name drug when a generic medicine is available. This plan has a Preferred Pharmacy Network.
	Preferred brand drugs (Tier 2)	$30 copayment (retail); $75 copayment (mail order)	Not Covered (retail); Not Covered (mail order)	
	Non-preferred brand drugs (Tier 3)	$60 copayment (retail); $150 copayment (mail order)	Not Covered (retail); Not Covered (mail order)	
	Specialty drugs (Tier 4)	Tier 1: $10 copay/30 day supply Tier 2: $30 copay/30 day supply Tier 3: $60 copay/ 30 day supply (specialty retail only)	Not Covered (specialty retail only)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copayment	Not Covered	None
	Physician/surgeon fees	$100 copayment	Not Covered	Preauthorization required.
If you need immediate medical attention	Emergency room care	$100 copayment	$100 copayment	Waived if admitted to Hospital.
	Emergency medical transportation	$100 copayment	$100 copayment	None
	Urgent care	$55 copayment	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment per admission	Not Covered	Preauthorization required, except for emergency admissions.
	Physician/surgeon fees	$100 copayment	Not Covered	Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: $15 copayment All Other Outpatient Services: $15 copayment	Not Covered	Unlimited visits. For Substance Abuse care, up to twenty (20) visits per plan year may be used for family counseling.
	Inpatient services	$500 copayment per admission	Not Covered	Preauthorization required, except for emergency admissions.
If you are pregnant	Office visits	No Charge	Not Covered	Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA will use the cost sharing for the appropriate service.
	Childbirth/delivery professional services	$100 copayment	Not Covered	Preauthorization required.
	Childbirth/delivery facility services	$500 copayment per admission	Not Covered	Limited to forty-eight (48) hours for natural delivery and ninety-six (96) hours for caesarean delivery. One (1) home care visit covered in full if discharged early. Preauthorization required.
If you need help recovering or have other special health needs	Home health care	$15 copayment	Not Covered	Forty (40) visits per plan year. Preauthorization required.
	Rehabilitation services	Inpatient: $500 copayment per admission Outpatient: $25 copayment	Not Covered	Inpatient: Sixty (60) days per condition/per plan year, combined therapies. Outpatient: Sixty (60) visits per condition/per plan year, combined therapies. Preauthorization required for Inpatient services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Habilitation services	Inpatient: $500 copayment per admission Outpatient: $25 copayment	Not Covered	Inpatient: Sixty (60) days per condition/per plan year, combined therapies. Outpatient: Sixty (60) visits per condition/per plan year, combined therapies. Preauthorization required for Inpatient services.
	Skilled nursing care	$500 copayment per admission	Not Covered	200 days per plan year. Preauthorization required.
	Durable medical equipment	10% coinsurance	Not Covered	None
	Hospice services	Inpatient: $500 copayment Outpatient: $15 copayment	Not Covered	210 days per plan year. Five (5) visits for family bereavement counseling. Preauthorization required for Inpatient services.
If your child needs dental or eye care	Children's eye exam	$15 copayment	Not Covered	One (1) exam per twelve (12) month period.
	Children's glasses	10% coinsurance	Not Covered	One (1) prescribed lenses and frames per twelve (12)-month period.
	Children's dental check-up	$15 copayment	Not Covered	One (1) dental exam & cleaning per six (6)-month period. Full mouth x-rays or panoramic x-rays.

Excluded Services & Other Covered Services

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Long-term care	• Routine foot care
• Cosmetic Surgery	• Non-emergency care when traveling outside the U.S.	• Routine hearing tests
• Dental Care (Adult)	• Private-duty nursing	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion Services	• Chiropractic care	• Infertility treatment (Prior Approval required)
• Bariatric Surgery (Prior Approval required)	• Hearing aids (Prior Approval required)	• Routine eye care

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: New York State Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov U.S. Department of Health and Human Services at 1-877-267-2323 x1565 or www.cciio.cms.gov, U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/contactEBSA/consumerassistance.html or www.dol.gov/ebsa/healthreform. 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 or NY State of Health Marketplace at 1-855-355-5777 or www.nystateofhealth.ny.gov.

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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

EmblemHealth
By Phone:
Please call the number on your ID card.
In writing:
EmblemHealth
Grievance and Appeals Department
P.O. Box 2801
New York, NY 10116-2807
Website: www.emblemhealth.com

For HMO Coverage
New York State Department of Health
By Phone: 1-800-206-8125
In writing:
New York State Department of Health
Office of Health Insurance Programs

For All Coverage Types
New York State Department of Financial Services
By Phone: 1-800-342-3736
In writing:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

Consumer Assistance Program
New York State Consumer Assistance Program
By Phone: 1-888-614-5400
In writing:
Community Health Advocates
633 Third Avenue, 10th Floor

* For more information about limitations and exceptions, see the plan or policy document at www.emblemhealth.com.

Bureau of Consumer Services - Complaint Unit Corning Tower - OCP Room 1607 Albany, NY 12237 Email: managedcarecomplaint@health.ny.gov Website: www.health.ny.gov	New York, NY 10017 Email: cha@cssny.org Website: www.communityhealthadvocates.org For Group Coverage: U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) Website: www.dol.gov/ebsa/healthreform

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 Coverage Meet the Minimum Value Standard? 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 1-888-447-8255.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-447-8255.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-447-8255.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-447-8255.

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 in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$500
Other copayment	$0

This EXAMPLE event includes services like:
Specialist office visits (prenatal 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	$2,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$500
Other copayment	$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	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,355

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$500
Other copayment	$0

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

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$980
Coinsurance	$4
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$984

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-390-3522.
*Note: This plan may have other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

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ATTENTION: Language assistance services, free of charge, are available to you. Call **1-877-411-3625**. TTY/TDD: **711**.

Español (Spanish)
ATENCIÓN: Usted tiene a su disposición, gratis, servicios de ayuda para idiomas. Llame al **1-877-411-3625** (TTY/TDD: **711**).

中文 (Traditional Chinese)
注意：我們免費提供相關的語言協助服務。請致電 **1-877-411-3625** (TTY/TDD: **711**)。

Русский (Russian)
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика. Звоните по тел. **1-877-411-3625** (служба текстового телефона TTY/TDD: **711**).

Kreyòl Ayisyen (Haitian Creole)
ATANSYON: Gen sèvis èd nan lang gratis ki disponib pou ou. Rele nimewo **1-877-411-3625** (TTY/TDD: **711**).

한국어 (Korean)
주의: 귀하에게 언어 지원 서비스가 무료로 제공됩니다. **1-877-411-3625**(TTY/TDD: **711**)번으로 전화하십시오.

Italiano (Italian)
ATTENZIONE: sono disponibili servizi gratuiti di assistenza linguistica. Chiami il numero **1-877-411-3625** (TTY/TDD: **711**).

אידיש (Yiddish)
אכטונג: שפראך הילף סערוויסעס, אהן קיין פרייז, זיינען דא צו באקומען פאר אייך. רופט **1-877-411-3625** (TTY/TDD: **711**).

বাংলা (Bengali)
মনোযোগ দিন: ভাষা সহায়তা পরিষেবাগুলি আপনার জন্য বিনামূল্যে উপলব্ধ আছে। **1-877-411-3625** (TTY/TDD: **711**) নম্বরে ফোন করুন।

Polski (Polish)
UWAGA: dostępna jest bezpłatna pomoc językowa. Prosimy zadzwonić pod numer **1-877-411-3625** (TTY/TDD: **711**).

العربية (Arabic)
يُرجى الانتباه: تتوفر لك خدمات المساعدة اللغوية مجاناً، اتصل على الرقم **1-877-411-3625** أو (TTY/TDD: **711**).

Français (French)
ATTENTION : une assistance d'interprétation gratuite est à votre disposition. Veuillez composer le **1-877-411-3625** (TTY/TDD : **711**).

اردو (Urdu)
توجہ دیں: آپ کے لیے زبان سے متعلق اعانت کی خدمات، مفت دستیاب ہیں۔ **1-877- 411-3625** (TTY/TDD: **711**) پر کال کریں۔

Tagalog (Tagalog)
NANANAWAGAN NG PANSIN: Mayroon kang magagamit na mga serbisyo para sa tulong sa wika nang walang bayad. Tawagan ang **1-877-411-3625** (TTY/TDD: **711**).

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ: Διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε το **1-877-411-3625** (για άτομα με προβλήματα ακοής (TTY/TDD): **711**).

Shqip (Albanian)
VINI RE: Shërbime ndihmore për gjuhën, falas, janë në dispozicionin tuaj. Telefononi në **1-877-411-3625** (TTY/TDD: **711**).

NOTICE OF NONDISCRIMINATION POLICY

EmblemHealth complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. EmblemHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

EmblemHealth:

- Provides free aids and services to people with disabilities to help
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call member services at **1-877-411-3625** (TTY/TDD: **711**).

If you believe that EmblemHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with EmblemHealth Grievance and Appeals Department, PO Box 2844, New York, NY 10116, or call member services at **1-877-411-3625**. (Dial **711** for TTY/TDD services.) You can file a grievance in person, by mail or by phone. If you need help filing a grievance, EmblemHealth's Grievance and Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at **U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201**; **1-800-368-1019**, (dial **1-800-537-7697** for TTY services).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

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