EmblemHealth®

Benefit Summaries

2022 Standard and Nonstandard Individual and Family Plans

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EmblemHealth Individual and Family Plans

For more than 80 years, EmblemHealth companies have offered quality, affordable health insurance to the New York community. It's what we do.

This Summary of Benefits brochure shares our Standard and Nonstandard Individual and Family HMO plans available from EmblemHealth. We have many plans designed to meet your health care insurance needs and budget.

How Do I Enroll?

Joining an EmblemHealth plan is easy.

For plans on the NY State of Health Marketplace exchange, go to the **nystateofhealth.ny.gov** site.

You will need to have certain information with you. Before applying, gather these items for each member of your household who needs health care coverage:

- **Social Security numbers** (or document numbers for legal immigrants)
- **Employer and income information** (for example, from your pay stubs or W-2 forms — Wage and Tax Statements)
- **Policy numbers** for any current health insurance plans covering members of your household
- **Email address**

To enroll directly with EmblemHealth, simply complete the enclosed HMO application and return it in the return envelope provided, along with payment, to EmblemHealth. Or, you can visit **emblemhealth.com**.
If you have any questions about these plans, you can reach us at **866-838-9144**, seven days a week, 8 am to 8 pm (TTY: **711**).

OUR STANDARD AND NONSTANDARD HEALTH PLANS

You can purchase the following EmblemHealth Standard and Nonstandard plans on the NY State of Health Marketplace:	
EmblemHealth Platinum	EmblemHealth Gold Premier
EmblemHealth Gold	EmblemHealth Gold Value
EmblemHealth Silver	EmblemHealth Silver Value
EmblemHealth Bronze	EmblemHealth Silver Bold
EmblemHealth Basic	

You can purchase the following plans directly through EmblemHealth:	
EmblemHealth Platinum D	EmblemHealth Gold Premier D
EmblemHealth Gold D	EmblemHealth Gold Value D
EmblemHealth Silver D	EmblemHealth Silver Value D
EmblemHealth Bronze D	EmblemHealth Silver Bold D
EmblemHealth Basic D	

All of these plans are health maintenance organization (HMO) plans. With an HMO plan, you choose a primary care provider (PCP) who will provide your everyday care, with the exception of the new Gold Premier non-gated plan.

- The Nonstandard Gold Premier, Nonstandard Gold Value, Nonstandard Silver Value, and Nonstandard Silver Bold plans offer unique benefits such as **3 no-cost PCP visits, specialist visits, urgent care visits, generic drugs, and lab services before the deductible. The Nonstandard plans also offer adult dental and vision services, and acupuncture before the deductible.** Under the Nonstandard plans, benefits that are subject to the deductible (the amount you pay each year before your plan starts to pay benefits) require you pay nothing out-of-pocket once that deductible is met with the exception of the Gold Premier plan.
- EmblemHealth offers adult dental and vision as well as pediatric dental benefits on all Nonstandard plans for children up to age 19. EmblemHealth offers pediatric dental benefits on all Standard plans for children up to age 19.

Tax credits — what the U.S. government provides to help people pay for the monthly costs of a health plan — are available to eligible people who enroll in certain qualified health plans on the NY State of Health Marketplace.

Network

EmblemHealth Nonstandard Qualified Health Plans, Gold Premier, Gold Value, and Silver Value plans use the **Select Care Network**. The network includes a carefully chosen group of health care professionals who together cover all medical specialties. EmblemHealth Silver Bold uses the **Millennium Network**, a tailored network within eight downstate counties.[1] The **Select Care Network** and the **Millennium Network** include AdvantageCare Physicians (ACPNY), one of the largest medical groups in the New York metro area.

Service Area

To join one of the EmblemHealth Standard plans, Nonstandard Gold Premier, Nonstandard Gold Value, or Silver Value plans, you must live in New York City (Brooklyn, the Bronx, Manhattan, Queens, or Staten Island), Long Island (Nassau or Suffolk counties), Westchester, Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, or Washington counties.

To join the Nonstandard Silver Bold plan, you must live in New York City (Brooklyn, the Bronx, Manhattan, Queens, or Staten Island), Long Island (Nassau or Suffolk counties), or Westchester county.

Glossary

A **premium** is the amount you pay for your insurance every month.

A **deductible** is the amount you pay each year before your plan starts to pay benefits.

A **copayment** (also called a "copay") is the set amount you pay for covered health services, like seeing a doctor or paying for a drug at the pharmacy.

Coinsurance is the percentage you pay for health services, usually after you pay your deductible.

A **network** is a group of health care professionals or facilities that have contracted with a health plan. They provide covered products and services to members.

A **non-gated** plan is a plan that does not require a referral from your PCP to see a specialist.

Out-of-pocket costs are what you pay for health services. These include deductibles, coinsurance, and copayments.

A **referral** is permission or approval from your doctor to see a specialist.

Tax credits are a form of financial assistance from the U.S. government to help people pay for the monthly costs of their health plan (the premium).

IMPORTANT THINGS YOU NEED TO KNOW ABOUT THESE PLANS

Here are a few important things you need to know about these plans:

- You need to select a primary care provider (PCP) who participates in your plan network with the exception of the Nonstandard Gold Premier plan.
- You have in-network coverage only, except hospital care for an emergency condition is covered in- or out-of-network.
- You'll need a "referral" or approval from your primary care provider to see specialists when needed. Specialists are doctors who provide services other than primary care, such as allergists, dermatologists, cardiologists, etc. You do not need referrals to see specialists if you choose the Nonstandard Gold Premier plan.
- You do not need an approval for all services. For example, you don't need approval from your primary care provider for:
  - Chiropractic services
  - Outpatient mental health services
  - Primary gynecologic and obstetric care
  - Refractive eye exams from an optometrist for covered children (this is only covered up to the end of the month in which you turn 19)
  - Diabetic eye exams from an ophthalmologist
  - Dental and vision services
- Preventive care is usually covered in full and not subject to any deductible as long as you use a participating health care professional. These services include routine physicals, screenings, immunizations, mammograms, gynecological exams, well-baby care, and prescription contraceptives for women.
- Prescription drug coverage is included in these plans. All prescription drug benefits must be obtained through pharmacies that contract with your plan. The pharmacist will apply any plan deductibles or copays when you pay for your prescription.

EmblemHealth Plans

NONSTANDARD PLANS

EmblemHealth Gold Premier/Gold Premier D

EmblemHealth Gold Premier is an HMO plan that has a lower deductible than the Gold Value plan and does not require referrals for specialist visits. The plan offers three $0 copay PCP visits, generic drugs, telemedicine at no cost, adult dental and vision, and urgent care before the deductible.

Summary of Benefits	
Major Cost-Sharing Provisions	**Copay/Limitations**
Primary care provider (PCP) office visits	3 $0 copay visits, then $25 copay per visit before deductible
Specialist office visits	$45 copay per visit before deductible
Telemedicine	Covered in full
Hospital admission	20% coinsurance after deductible
Emergency room copay (waived if admitted)	20% coinsurance after deductible
Annual deductible (individual/family)	$800/$1,600
Annual out-of-pocket maximum (individual/family)	$6,200/$12,400
Prescription drugs	$0 copay generic before deductible, $60 copay preferred brand after deductible, $80 copay non-preferred brand after deductible, $80 copay specialty drugs after deductible
Inpatient Hospital Services	**Copay/Limitations**
Inpatient physician and surgical services	$350 copay after deductible
Semi-private room and board	Included in hospital admission copay after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, x-rays, and lab tests	Included in hospital admission copay after deductible
Short-term speech, physical, occupational, and respiratory therapy (when part of an acute admission)	Included in hospital admission copay after deductible, short-term only
Speech, physical, occupational, and respiratory therapy (when part of a rehabilitation admission)	Included in hospital admission copay after deductible
Radiation therapy and chemotherapy	$25/$45 copay after deductible
Pre-admission testing	$0 after deductible
Outpatient Medical Care	**Copay/Limitations**
PCP office visits	Subject to PCP office visit copay after deductible
Specialist office visits	Subject to specialist office visit copay after deductible
Preventive care* including physical exams, ear exams, health education and counseling, pap smear, mammography, and immunizations	Covered in full
Well-child care*	Covered in full
Diagnostic laboratory services	$25 (PCP)/$45 (specialist) copay before deductible
Prenatal care in physican's office	Covered in full
Ambulatory surgery	$350 copay after deductible
Second medical and surgical opinion	$45 copay per visit after deductible
Chiropractic services	$45 copay per visit before deductible
Acupuncture	Covered in full
Mental Health and Substance Use Disorder	**Copay/Limitations**
Mental health care	
Inpatient treatment of mental illness	Subject to hospital admission copay after deductible; no limit on days per calendar year
Outpatient treatment of mental illness	3 $0 copay visits, then $25 copay per visit before deductible; no limit on visits per calendar year
Substance use disorder	
Inpatient detoxification	Subject to hospital admission copay after deductible; no limit on days per calendar year

Summary of Benefits	
Inpatient rehabilitation treatment	Subject to hospital admission copay after deductible; no limit on days per calendar year
Outpatient rehabilitation treatment	3 $0 copay visits, then $25 copay per visit before deductible; no limit on visits per calendar year
Special Kinds of Care	**Copay/Limitations**
Emergency and urgent care	
In hospital emergency room	20% coinsurance after deductible (waived if admitted)
In urgent care facility	$75 copay before deductible
Ambulance service to the hospital	$350 copay after deductible
Home health care	$45 copay after deductible.
Hospice care	$45 copay after deductible
Skilled nursing facility care	Subject to hospital admission copay after deductible
Dialysis treatment	$25/$45 copay after deductible
Diabetes equipment, supplies, and education	$25 copay before deductible
Outpatient physical, speech, occupational, and respiratory therapy	$25/$45 copay after deductible
Family planning services	Covered in full
Infertility diagnosis and treatment	Covered in full
Durable medical equipment	20% coinsurance after deductible
Hearing aids	20% coinsurance after deductible
Pediatric Dental Benefits	**Copay/Limitations**
Emergency dental care	$25 copay before deductible
Preventive dental care (dental exam and cleaning)	$0 copay before deductible/1 every 6 months
Routine dental care	$25 copay before deductible
Major dental care	$45 copay after deductible
Orthodontics	$45 copay after deductible
Pediatric Vision Care Benefits	**Copay/Limitations**
Exams	$0 copay before deductible/1 every 12 months
Lenses and frames	20% coinsurance before deductible/1 every 12 months
Contact lenses	20% coinsurance before deductible/1 every 12 months
Adult Dental Benefits	**Copay/Limitations**
Emergency dental care	$25 before deductible
Preventive dental care (dental exam and cleaning)	$0 copay before deductible/1 every 6 months
Routine dental care	$25 copay before deductible
Adult Vision Care Benefits	**Copay/Limitations**
Exams	$0 copay before deductible/1 every 12 months
Lenses and frames	20% coinsurance before deductible/1 every 12 months
Contact lenses	20% coinsurance before deductible/1 every 12 months

EmblemHealth Qualified Health Plans are underwritten by Health Insurance Plan of Greater New York (HIP). Except for emergency care, the above benefits and services are covered only when provided by a Select Care Network primary care provider and/or approved in advance by the EmblemHealth Utilization Management Program. Participating physicians and providers have contracted with EmblemHealth to provide care to our members; they are not employees, agents, servants, or representatives of EmblemHealth. This summary is provided for information only; it does not contain complete details of the plan, which are available only in the Contract or Certificate of Coverage, and it does not constitute an agreement. Refer to HIP policy form number 155-23-NSIONHIXGPremierSchedule (04/21).

* Preventive care and well-child care services are covered in full in-network when given an A or B rating by the United States Preventive Services Task Force (USPSTF), recommended by the Advisory Committee on Immunization Practices (ACIP), or provided in accordance with Health Resources and Services Administration (HRSA) guidelines. Other preventive care services may be subject to cost-sharing.

Certain services must be approved in advance by EmblemHealth.

EmblemHealth Gold Value/Gold Value D

EmblemHealth Gold Value is an HMO plan with a higher deductible than the Standard Gold plan, but with benefits not offered by the Standard Gold plan such as three $0 copay PCP visits, specialist visits, generic drugs and urgent care before the deductible, and benefits for dental and vision services for adults and children.

SUMMARY OF BENEFITS	
Major Cost-Sharing Provisions	**Copay/Limitations**
Primary care provider (PCP) office visits	3 $0 copay visits, then $45 copay per visit before deductible
Specialist office visits	$65 copay per visit before deductible
Telemedicine	Covered in full
Hospital admission	$0 copay per hospital admission after deductible
Emergency room copay (waived if admitted)	$0 copay per visit after deductible
Annual deductible (individual/family)	$4,000/$8,000
Annual out-of-pocket maximum (individual/family)	$4,000/$8,000
Prescription drugs	$10 copay before deductible (generics), $0 after deductible (brand)
Inpatient Hospital Services	**Copay/Limitations**
Inpatient physician and surgical services	$0 copay after deductible
Semi-private room and board	Included in hospital admission copay after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, x-rays, and lab tests	Included in hospital admission copay after deductible
Short-term speech, physical, occupational, and respiratory therapy (when part of an acute admission)	Included in hospital admission copay after deductible
Speech, physical, occupational, and respiratory therapy (when part of a rehabilitation admission)	Included in hospital admission copay after deductible
Radiation therapy and chemotherapy	$0 copay after deductible
Pre-admission testing	$0 copay after deductible
Outpatient Medical Care	**Copay/Limitations**
PCP office visits	$45 copay before deductible
Specialist office visits	$65 copay before deductible
Preventive care* including physical exams, ear exams, health education and counseling, pap smear, mammography, and immunizations	Covered in full
Well-child care*	Covered in full
Diagnostic laboratory services	$45 (PCP)/$65 (specialist) copay before deductible
Prenatal care in physican's office	Covered in full
Ambulatory surgery	$0 copay after deductible
Second medical and surgical opinion	$0 copay after deductible
Chiropractic services	$65 copay before deductible
Acupuncture	Covered in full
Mental Health and Substance Use Disorder	**Copay/Limitations**
Mental health care	
Inpatient treatment of mental illness	$0 after deductible
Outpatient treatment of mental illness	3 $0 copay visits, then $45 copay per visit before deductible; no limit on visits per calendar year
Substance use disorder	
Inpatient detoxification	$0 after deductible
Inpatient rehabilitation treatment	$0 after deductible
Outpatient rehabiliation treatment	3 $0 copay visits, then $45 copay per visit before deductible; no limit on visits per calendar year

SUMMARY OF BENEFITS	
Special Kinds of Care	**Copay/Limitations**
Emergency and urgent care	
In hospital emergency room	$0 copay after deductible
In urgent care facility	$75 copay before deductible
Ambulance service to the hospital	$0 copay after deductible
Home health care	$0 copay after deductible
Hospice care	$0 copay after deductible
Skilled nursing facility care	$0 copay after deductible
Dialysis treatment	$0 copay after deductible
Diabetes equipment, supplies, and education	$45 copay before deductible
Outpatient physical, speech, occupational, and respiratory therapy	$0 copay after deductible
Family planning services	Covered in full
Infertility diagnosis and treatment	$0 copay after deductible
Durable medical equipment	0% coinsurance
Hearing aids	0% coinsurance
Pediatric Dental Benefits	**Copay/Limitations**
Emergency dental care	$45 copay before deductible
Preventive dental care (dental exam and cleaning)	Covered in full/1 every 6 months
Routine dental care	$45 copay before deductible
Major dental care	$0 after deductible
Orthodontics	$0 after deductible
Pediatric Vision Care Benefits	**Copay/Limitations**
Exams	$0 copay after deductible/1 every 12 months
Lenses and frames	20% coinsurance before deductible/1 every 12 months
Contact lenses	20% coinsurance before deductible/1 every 12 months
Adult Dental Benefits	**Copay/Limitations**
Emergency dental care	$45 copay before deductible
Preventive dental care (dental exam and cleaning)	Covered in full/1 every 6 months
Routine dental care	$45 copay before deductible
Adult Vision Care Benefits	**Copay/Limitations**
Exams	$0 copay before deductible/1 every 12 months
Lenses and frames	20% coinsurance before deductible/1 every 12 months
Contact lenses	20% coinsurance before deductible/1 every 12 months

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* Preventive care and well-child care services are covered in full in-network when given an A or B rating by the United States Preventive Services Task Force (USPSTF), recommended by the Advisory Committee on Immunization Practices (ACIP), or provided in accordance with Health Resources and Services Administration (HRSA) guidelines. Other preventive care services may be subject to cost-sharing.

Certain services must be approved in advance by EmblemHealth.

EmblemHealth Silver Value/Silver Value D

EmblemHealth Silver Value is an HMO plan with a higher deductible than the Standard Silver plan; however, you can use certain benefits without meeting your deductible. This plan offers unique benefits such as 3 $0 copay PCP visits, specialist visits, generic drugs and urgent care before the deductible, and benefits for dental and vision services for adults and children.

Summary of Benefits	
Major Cost-Sharing Provisions	**Copay/Limitations**
Primary care provider (PCP) office visits	3 $0 copay visits, then $35 copay per visit before deductible
Specialist office visits	$75 copay per visit before deductible
Telemedicine	$0 copay before deductible
Hospital admission	$0 copay per hospital admission after deductible
Emergency room copay (waived if admitted)	$0 copay per visit after deductible
Annual deductible (individual/family)	$6,300/$12,600
Annual out-of-pocket maximum (individual/family)	$6,300/$12,600
Prescription drugs	$10 copay before deductible (generics), $0 after deductible (brand)
Inpatient Hospital Services	**Copay/Limitations**
Inpatient physician and surgical services	$0 copay before deductible
Semi-private room and board	Included in hospital admission copay after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, x-rays and lab tests	Included in hospital admission copay after deductible
Short-term speech, physical, occupational, and respiratory therapy (when part of an acute admission)	Included in hospital admission copay after deductible
Speech, physical, occupational, and respiratory therapy (when part of a rehabilitation admission)	Included in hospital admission copay after deductible, short-term only
Radiation therapy and chemotherapy	$0 copay after deductible
Pre-admission testing	$0 copay before deductible
Outpatient Medical Care	**Copay/Limitations**
PCP office visits	$35 copay per visit before deductible
Specialist office visits	$75 copay per visit before deductible
Preventive care* including physical exams, ear exams, health education and counseling, pap smear, mammography, and immunizations	Covered in full
Well-child care	Covered in full
Diagnostic Laboratory Services	$35 (PCP)/$75 (specialist) copay before deductible
Prenatal care in physican's office	Covered in full
Ambulatory surgery	$0 copay after deductible
Second medical and surgical opinion	$0 copay after deductible
Chiropractic services	$75 copay before deductible
Acupuncture	Covered in full
Mental Health and Substance Use Disorder	**Copay/Limitations**
Mental health care	
Inpatient treatment of mental illness	$0 copay before deductible
Outpatient treatment of mental illness	3 $0 copay visits, the $35 copay per visit before deductible; no limit on visits per calendar year
Substance use disorder	
Inpatient detoxification	$0 copay after deductible
Inpatient rehabilitation treatment	$0 copay after deductible
Outpatient rehabilitation treatment	3 $0 copay visits, the $35 copay per visit before deductible; no limit on visits per calendar year

Summary of Benefits	
Special Kinds of Care	**Copay/Limitations**
Emergency and urgent care	
In hospital emergency room	$0 copay per visit after deductible (waived if admitted)
In urgent care facility	$75 copay before deductible
Ambulance service to the hospital	$0 copay after deductible
Home health care	$0 copay after deductible
Hospice care	$0 copay after deductible
Skilled nursing facility care	Subject to hospital admission copay after deductible
Dialysis treatment	$0 copay after deductible
Diabetes equipment, supplies, and education	$35 copay before deductible
Outpatient physical, speech, occupational, and respiratory therapy	$0 copay after deductible
Family planning services	Covered in full
Infertility diagnosis and treatment	Covered in full
Durable medical equipment	$0 coinsurance after deductible
Hearing aids	$0 coinsurance after deductible
Pediatric Dental Benefits	**Copay/Limitations**
Emergency dental care	$35 copay before deductible
Preventive dental care (dental exam and cleaning)	$0 copay before deductible/1 every 12 months
Routine dental care	$35 copay before deductible
Major dental care	$0 copay after deductible
Orthodontics	$0 copay after deductible
Pediatric Vision Care Benefits	**Copay/Limitations**
Exams	$0 copay before deductible/1 every 12 months
Lenses and frames	30% coinsurance before deductible/1 every 12 months
Contact lenses	30% coinsurance before deductible/1 every 12 months
Adult Dental Benefits	**Copay/Limitations**
Emergency dental care	$35 copay before deductible
Preventive dental care (dental exam and cleaning)	$0 copay before deductible/1 every 6 months
Routine dental care	$35 copay before deductible
Adult Vision Care Benefits	**Copay/Limitations**
Exams	$0 copay before deductible/1 every 12 months
Lenses and frames	30% coinsurance before deductible/1 every 12 months
Contact lenses	30% coinsurance before deductible/1 every 12 months

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* Preventive care and well-child care services are covered in full in-network when given an A or B rating by the United States Preventive Services Task Force (USPSTF), recommended by the Advisory Committee on Immunization Practices (ACIP), or provided in accordance with Health Resources and Services Administration (HRSA) guidelines. Other preventive care services may be subject to cost-sharing.

Certain services must be approved in advance by EmblemHealth.

EmblemHealth Silver Bold/Silver Bold D

EmblemHealth Silver Bold is a lower-cost HMO plan on the new Millennium Network. It features benefits not offered by the Standard plans such as three $0 copay PCP visits, specialist visits, generic drugs and urgent care before the deductible, and benefits for dental and vision services for adults and children.

Summary of Benefits	
Major Cost-Sharing Provisions	**Copay/Limitations**
Primary care provider (PCP) office visits	3 $0 copay visits, then $50 copay per visit before deductible
Specialist office visits	$70 copay per visit before deductible
Telemedicine	Covered in full
Hospital admission	$0 copay per hospital admission after deductible
Emergency room copay (waived if admitted)	$0 copay per visit after deductible
Annual deductible (individual/family)	$6,500/$13,000
Annual out-of-pocket maximum (individual/family)	$6,500/$13,000
Prescription drugs	$15 copay before deductible (generics), $0 after deductible (brand)
Inpatient Hospital Services	**Copay/Limitations**
Inpatient physician and surgical services	$0 copay after deductible
Semi-private room and board	Included in hospital admission copay after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, x-rays, and lab tests	Included in hospital admission copay after deductible
Short-term speech, physical, occupational, and respiratory therapy (when part of an acute admission)	Included in hospital admission copay after deductible
Speech, physical, occupational, and respiratory therapy (when part of a rehabilitation admission)	Included in hospital admission copay after deductible
Radiation therapy and chemotherapy	$0 copay after deductible
Pre-admission testing	$0 copay before deductible
Outpatient Medical Care	**Copay/Limitations**
PCP office visits	$50 copay per visit before deductible
Specialist office visits	$70 copay per visit before deductible
Preventive care* including physical exams, ear exams, health education and counseling, pap smear, mammography, and immunizations	Covered in full
Well-child care*	Covered in full
Diagnostic Laboratory Services	$50 (PCP)/$70 (specialist) copay before deductible
Prenatal care in physician's office	Covered in full
Ambulatory surgery	$0 copay after deductible
Second medical and surgical opinion	$0 copay after deductible
Chiropractic services	$70 copay before deductible
Acupuncture	Covered in full
Mental Health and Substance Use Disorder	**Copay/Limitations**
Mental health care	
Inpatient treatment of mental illness	$0 copay after deductible
Outpatient treatment of mental illness	3 $0 copay visits, the $50 copay per visit before deductible; no limit on visits per calendar year
Substance use disorder	
Inpatient detoxification	$0 copay after deductible
Inpatient rehabilitation treatment	$0 copay after deductible
Outpatient rehabilitation treatment	3 $0 copay visits, then $50 copay per visit before deductible; no limit on visits per calendar year

Summary of Benefits	
Special Kinds of Care	**Copay/Limitations**
Emergency and urgent care	
In hospital emergency room	$0 copay after deductible
In urgent care facility	$75 copay before deductible
Ambulance service to the hospital	$0 copay after deductible
Home health care	$0 copay after deductible
Hospice care	$0 copay after deductible
Skilled nursing facility care	$0 copay after deductible
Dialysis treatment	$0 copay after deductible
Diabetes equipment, supplies, and education	$50 copay before deductible
Outpatient physical, speech, occupational, and respiratory therapy	$0 copay after deductible
Family planning services	Covered in full
Infertility diagnosis and treatment	$0 copay after deductible
Durable medical equipment	0% coinsurance after deductible
Hearing aids	0% coinsurance after deductible
Pediatric Dental Benefits	**Copay/Limitations**
Emergency dental care	$50 copay before deductible
Preventive dental care (dental exam and cleaning)	Covered in full/1 every 6 months
Routine dental care	$50 copay before deductible
Major dental care	$0 copay after deductible
Orthodontics	$0 copay after deductible
Pediatric Vision Care Benefits	**Copay/Limitations**
Exams	$0 copay before deductible/1 every 12 months
Lenses and frames	30% coinsurance before deductible/1 every 12 months
Contact lenses	30% coinsurance before deductible/1 every 12 months
Adult Dental Benefits	**Copay/Limitations**
Emergency dental care	$50 copay before deductible
Preventive dental care (dental exam and cleaning)	Covered in full/1 every 6 months
Routine dental care	$50 copay before deductible
Adult Vision Care Benefits	**Copay/Limitations**
Exams	$0 copay before deductible/1 every 12 months
Lenses and frames	30% coinsurance before deductible/1 every 12 months
Contact lenses	30% coinsurance before deductible/1 every 12 months

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* Preventive care and well-child care services are covered in full in-network when given an A or B rating by the United States Preventive Services Task Force (USPSTF), recommended by the Advisory Committee on Immunization Practices (ACIP), or provided in accordance with Health Resources and Services Administration (HRSA) guidelines. Other preventive care services may be subject to cost-sharing.

Certain services must be approved in advance by EmblemHealth.

STANDARD PLANS

EmblemHealth Platinum/EmblemHealth Platinum D

EmblemHealth Platinum is an HMO plan with no annual deductible and low out-of-pocket costs. All of EmblemHealth's individual and family plans cover the same health benefits, but at different monthly premiums and out-of-pocket costs.

Summary of Benefits	
Major Cost-Sharing Provisions	**Copay/Limitations**
Primary care provider (PCP) office visits	$15 copay per visit
Specialist office visits	$35 copay per visit
Telemedicine	Covered in full
Hospital admission	$500 copay per hospital admission
Emergency room copay (waived if admitted)	$100 copay per visit
Annual deductible (individual/family)	$0/$0
Annual out-of-pocket maximum (individual/family)	$2,000/$4,000
Prescription drugs	$10 copay generic, $30 copay preferred brand, $60 copay non-preferred brand, $60 copay specialty drugs
Inpatient Hospital Services	**Copay/Limitations**
Inpatient physician and surgical services	$100 copay
Semi-private room and board	Included in hospital admission copay
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, x-rays, and lab tests	Included in hospital admission copay
Short-term speech, physical, occupational, and respiratory therapy (when part of an acute admission)	Included in hospital admission copay
Speech, physical, occupational, and respiratory therapy (when part of a rehabilitation admission)	Included in hospital admission copay
Radiation therapy and chemotherapy	Subject to PCP office visit copay
Pre-admission testing	Covered in full
Outpatient Medical Care	**Copay/Limitations**
PCP office visits	Subject to PCP office visit copay
Specialist office visits	Subject to specialist office visit copay
Preventive care* including physical exams, ear exams, health education and counseling, pap smear, mammography, and immunizations	Covered in full
Well-child care*	Covered in full
Diagnostic laboratory services	$15 (PCP)/$35 (specialist) copay
Prenatal care in physican's office	Covered in full
Ambulatory surgery	$100 copay
Second medical and surgical opinion	Subject to specialist office visit copay
Chiropractic services	Subject to specialist office visit copay
Mental Health and Substance Use Disorder	**Copay/Limitations**
Mental health care	
Inpatient treatment of mental illness	Subject to hospital admission copay; no limit on days per calendar year
Outpatient treatment of mental illness	Subject to PCP office visit copay; no limit on days per calendar year
Substance use disorder	
Inpatient detoxification	Subject to hospital admission copay; no limit on days per calendar year
Inpatient rehabilitation treatment	Subject to hospital admission copay; no limit on days per calendar year
Outpatient rehabilitation treatment	Subject to PCP office visit copay; no limit on days per calendar year

Summary of Benefits	
Special Kinds of Care	**Copay/Limitations**
Emergency and urgent care	
In hospital emergency room	$100 copay per visit (waived if admitted)
In urgent care facility	$55 copay
Ambulance service to the hospital	$100 copay
Home health care	Subject to PCP office visit copay
Hospice care	Subject to PCP office visit copay
Skilled nursing facility care	Subject to hospital admission copay
Dialysis treatment	Subject to PCP office visit copay
Diabetes equipment, supplies, and education	Subject to PCP office visit copay
Outpatient physical, speech, occupational, and respiratory therapy	$25 copay
Family planning services	Covered in full
Infertility diagnosis and treatment	Covered in full
Durable medical equipment	10% coinsurance
Hearing aids	10% coinsurance
Pediatric Dental Benefits	**Copay/Limitations**
Emergency dental care	$15 copay
Preventive dental care (dental exam and cleaning)	$15 copay/1 every 6 months
Routine dental care	$15 copay
Major dental care	$15 copay
Orthodontics	$15 copay
Pediatric Vision Care Benefits	**Copay/Limitations**
Exams	$15 copay/1 every 12 months
Lenses and frames	10% coinsurance/1 every 12 months
Contact lenses	10% coinsurance/1 every 12 months

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EmblemHealth Gold/EmblemHealth Gold D

EmblemHealth Gold is an HMO plan with the second-lowest cost-sharing of the EmblemHealth metal plans. All of EmblemHealth's individual and family plans cover the same health benefits, but at different monthly premiums and out-of-pocket costs.

Summary of Benefits	
Major Cost-Sharing Provisions	**Copay/Limitations**
Primary care provider (PCP) office visits	$25 copay per visit after deductible
Specialist office visits	$40 copay per visit after deductible
Telemedicine	Covered in full
Hospital admission	$1,000 copay per visit after deductible
Emergency room copay (waived if admitted)	$150 copay per visit after deductible
Annual deductible (individual/family)	$600/$1,200
Annual out-of-pocket maximum (individual/family)	$4,000/$8,000
Prescription drugs	$10 copay generic, $35 copay preferred brand, $70 copay non-preferred brand, $70 copay specialty drugs
Inpatient Hospital Services	**Copay/Limitations**
Inpatient physician and surgical services	$100 copay after deductible
Semi-private room and board	Included in hospital admission copay after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, x-rays, and lab tests	Included in hospital admission copay after deductible
Short-term speech, physical, occupational, and respiratory therapy (when part of an acute admission)	Included in hospital admission copay after deductible, short-term only
Speech, physical, occupational, and respiratory therapy (when part of a rehabilitation admission)	Included in hospital admission copay after deductible
Radiation therapy and chemotherapy	Subject to PCP office visit copay after deductible
Pre-admission testing	$0 after deductible
Outpatient Medical Care	**Copay/Limitations**
PCP office visits	Subject to PCP office visit copay after deductible
Specialist office visits	Subject to specialist office visit copay after deductible
Preventive care* including physical exams, ear exams, health education and counseling, pap smear, mammography, and immunizations	Covered in full
Well-child care*	Covered in full
Diagnostic laboratory aervices	$25 (PCP)/$40 (specialist) copay after deductible
Prenatal care in physican's office	Covered in full
Ambulatory surgery	$100 copay after deductible
Second medical and surgical opinion	Subject to specialist office visit copay after deductible
Chiropractic services	Subject to specialist office visit copay after deductible
Mental Health and Substance Use Disorder	**Copay/Limitations**
Mental health care	
Inpatient treatment of mental illness	Subject to hospital admission copay after deductible; no limit on days per calendar year
Outpatient treatment of mental illness	Subject to PCP office visit copay after deductible; no limit on visits per calendar year
Substance use disorder	
Inpatient detoxification	Subject to hospital admission copay after deductible; no limit on days per calendar year
Inpatient rehabilitation treatment	Subject to hospital admission copay after deductible; no limit on days per calendar year
Outpatient rehabilitation treatment	Subject to PCP office visit copay after deductible; no limit on visits per calendar year

Summary of Benefits	
Special Kinds of Care	**Copay/Limitations**
Emergency and urgent care	
In hospital emergency room	$150 copay per visit after deductible (waived if admitted)
In urgent care facility	$60 copay after deductible
Ambulance service to the hospital	$150 copay after deductible
Home health care	Subject to PCP office visit copay after deductible
Hospice care	Subject to PCP office visit copay after deductible
Skilled nursing facility care	Subject to hospital admission copay after deductible
Dialysis treatment	Subject to PCP office visit copay after deductible
Diabetes equipment, supplies, and education	Subject to PCP office visit copay after deductible
Outpatient physical, speech, occupational, and respiratory therapy	$30 copay after deductible
Family planning services	Covered in full
Infertility diagnosis and treatment	Covered in full
Durable medical equipment	20% coinsurance after deductible
Hearing aids	20% coinsurance after deductible
Pediatric Dental Benefits	**Copay/Limitations**
Emergency dental care	$25 copay after deductible
Preventive dental care (dental exam and cleaning)	$25 copay after deductible/1 every 6 months
Routine dental care	$25 copay after deductible
Major dental care	$25 copay after deductible
Orthodontics	$25 copay after deductible
Pediatric Vision Care Benefits	**Copay/Limitations**
Exams	$25 copay after deductible/1 every 12 months
Lenses and frames	20% coinsurance after deductible/1 every 12 months
Contact lenses	20% coinsurance after deductible/1 every 12 months

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EmblemHealth Silver/EmblemHealth Silver D

EmblemHealth Silver is an HMO plan that offers eligible individuals lower monthly premiums and higher out-of-pocket costs. Just like the other metal plans available on the Marketplace, people may be eligible for tax credits. It is the most popular of the Standard metal plans.

Summary of Benefits	
Major Cost-Sharing Provisions	**Copay/Limitations**
Primary care provider (PCP) office visits	$30 copay per visit after deductible
Specialist office visits	$50 copay per visit after deductible
Telemedicine	Covered in full
Hospital admission	$1,500 copay per hospital admission after deductible
Emergency room copay (waived if admitted)	$300 copay per visit after deductible
Annual deductible (individual/family)	$1,300/$2,600
Annual out-of-pocket maximum (individual/family)	$8,500/$17,000
Prescription drugs	$10 copay generic, $35 copay preferred brand, $70 copay non-preferred brand, $70 copay specialty drugs
Inpatient Hospital Services	**Copay/Limitations**
Inpatient physician and surgical services	$150 copay after deductible
Semi-private room and board	Included in hospital admission copay after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, x-rays, and lab tests	Included in hospital admission copay after deductible
Short-term speech, physical, occupational, and respiratory therapy (when part of an acute admission)	Included in hospital admission copay after deductible, short-term only
Speech, physical, occupational, and respiratory therapy (when part of a rehabilitation admission)	Included in hospital admission copay after deductible
Radiation therapy and chemotherapy	Subject to PCP office visit copay after deductible
Pre-admission testing	$0 after deductible
Outpatient Medical Care	**Copay/Limitations**
PCP office visits	Subject to PCP office visit copay after deductible
Specialist office visits	Subject to specialist office visit copay after deductible
Preventive care* including physical exams, ear exams, health education and counseling, pap smear, mammography, and immunizations	Covered in full
Well-child care*	Covered in full
Diagnostic laboratory services	$30 PCP/$50 specialist after deductible
Prenatal care in physican's office	Covered in full
Ambulatory surgery	$150 copay after deductible
Second medical and surgical opinion	Subject to specialist office visit copay after deductible
Chiropractic services	Subject to specialist office visit copay after deductible
Mental Health and Substance Use Disorder	**Copay/Limitations**
Mental health care	
Inpatient treatment of mental illness	Subject to hospital admission copay after deductible; no limit on days per calendar year
Outpatient treatment of mental illness	Subject to PCP office visit copay after deductible; no limit on visits per calendar year
Substance use disorder	
Inpatient detoxification	Subject to hospital admission copay after deductible; no limit on days per calendar year
Inpatient rehabilitation treatment	Subject to hospital admission copay after deductible; no limit on days per calendar year
Outpatient rehabilitation treatment	Subject to PCP office visit copay after deductible; no limit on visits per calendar year

Summary of Benefits	
Special Kinds of Care	**Copay/Limitations**
Emergency and urgent care	
In hospital emergency room	$300 copay per visit after deductible (waived if admitted)
In urgent care facility	$70 copay after deductible
Ambulance service to the hospital	$150 copay after deductible
Home health care	Subject to PCP office visit copay after deductible
Hospice care	Subject to PCP office visit copay after deductible
Skilled nursing facility care	Subject to hospital admission copay after deductible
Dialysis treatment	Subject to PCP office visit copay after deductible
Diabetes equipment, supplies, and education	Subject to PCP office visit copay after deductible
Outpatient physical, speech, occupational, and respiratory therapy	Subject to PCP office visit copay after deductible
Family planning services	Covered in full
Infertility diagnosis and treatment	Covered in full
Durable medical equipment	30% coinsurance after deductible
Hearing aids	30% coinsurance after deductible
Pediatric Dental Benefits	**Copay/Limitations**
Emergency dental care	$30 copay after deductible
Preventive dental care (dental exam and cleaning)	$30 copay after deductible/1 every 6 months
Routine dental care	$30 copay after deductible
Major dental care	$30 copay after deductible
Orthodontics	$30 copay after deductible
Pediatric Vision Care Benefits	**Copay/Limitations**
Exams	$30 copay after deductible/1 every 12 months
Lenses and frames	30% coinsurance after deductible/1 every 12 months
Contact lenses	30% coinsurance after deductible/1 every 12 months

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Certain services must be approved in advance by EmblemHealth.

EmblemHealth Bronze/EmblemHealth Bronze D

EmblemHealth Bronze is an HMO plan that includes three annual visits to your primary care provider before your deductible. All of EmblemHealth's individual and family plans cover the same benefits, but at different monthly premiums and out-of-pocket costs.

Summary of Benefits	
Major Cost-Sharing Provisions	**Copay/Limitations**
Primary care provider (PCP) office visits	3 visits for $50 before deductible, thereafter $50 after deductible
Specialist office visits	3 visits for $75 before deductible, thereafter $75 after deductible
Telemedicine	Covered in full
Hospital admission	$1,500 copay after deductible
Emergency room copay (waived if admitted)	$500 copay after deductible
Annual deductible (individual/family)	$4,700/$9,400
Annual out-of-pocket maximum (individual/family)	$8,700/$17,400
Prescription drugs	$10 copay generic, $35 copay preferred brand, $70 copay non-preferred brand, $70 copay specialty drugs after deductible
Inpatient Hospital Services	**Copay/Limitations**
Inpatient physician and surgical services	$150 copay after deductible
Semi-private room and board	Included in hospital admission copay after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, x-rays, and lab tests	Included in hospital admission copay after deductible
Short-term speech, physical, occupational, and respiratory therapy (when part of an acute admission)	Included in hospital admission copay after deductible, short-term only
Speech, physical, occupational, and respiratory therapy (when part of a rehabilitation admission)	Included in hospital admission copay after deductible
Radiation therapy and chemotherapy	$50 copay after deductible
Pre-admission testing	$0 copay after deductible
Outpatient Medical Care	**Copay/Limitations**
PCP office visits	Subject to PCP office visit copay after deductible
Specialist office visits	Subject to specialist office visit copay after deductible
Preventive care* including physical exams, ear exams, health education and counseling, pap smear, mammography, and immunizations	Covered in full
Well-child care*	Covered in full
Diagnostic laboratory services	$50 copay after deductible
Prenatal care in physician's office	Covered in full
Ambulatory surgery	$150 copay after deductible
Second medical and surgical opinion	Subject to specialist office visit copay after deductible
Chiropractic services	Subject to specialist office visit copay after deductible
Mental Health and Substance Use Disorder	**Copay/Limitations**
Mental health care	
Inpatient treatment of mental illness	Subject to hospital admission copay after deductible; no limit on days per calendar year
Outpatient treatment of mental illness	Subject to PCP office visit copay after deductible; no limit on visits per calendar year
Substance use disorder	
Inpatient detoxification	Subject to hospital admission copay after deductible; no limit on days per calendar year
Inpatient rehabilitation treatment	Subject to hospital admission copay after deductible; no limit on days per calendar year
Outpatient rehabilitation treatment	Subject to PCP office visit copay after deductible; no limit on visits per calendar year

Summary of Benefits	
Special Kinds of Care	**Copay/Limitations**
Emergency and urgent care	
In hospital emergency room	$500 copay per visit after deductible (waived if admitted)
In urgent care facility	$75 after deductible
Ambulance service to the hospital	$300 copay after deductible
Home health care	$50 copay after deductible
Hospice care	$50 copay after deductible
Skilled nursing facility care	Subject to hospital admission copay after deductible
Dialysis treatment	$50 copay after deductible
Diabetes equipment, supplies, and education	$50 copay after deductible
Outpatient physical, speech, occupational, and respiratory therapy	$50 after deductible
Family planning services	Covered in full
Infertility diagnosis and treatment	Covered in full
Durable medical equipment	50% coinsurance after deductible
Hearing aids	50% coinsurance after deductible
Pediatric Dental Benefits	**Copay/Limitations**
Emergency dental care	$50 copay after deductible
Preventive dental care (dental exam and cleaning)	$50 copay after deductible/1 every 6 months
Routine dental care	$50 copay after deductible
Major dental care	$50 copay after deductible
Orthodontics	$50 copay after deductible
Pediatric Vision Care Benefits	**Copay/Limitations**
Exams	$50 copay after deductible/1 every 12 months
Lenses and frames	50% coinsurance after deductible/1 every 12 months
Contact lenses	50% coinsurance after deductible/1 every 12 months

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Certain services must be approved in advance by EmblemHealth.

EmblemHealth Basic

EmblemHealth Basic is an HMO plan for individuals under age 30 and others who qualify based on financial need. It includes three annual visits to a primary care provider before you meet the deductible. All of EmblemHealth's individual and family plans cover the same health benefits, but at different monthly premiums and out-of-pocket costs.

Summary of Benefits	
Major Cost-Sharing Provisions	**Copay/Limitations**
Primary care provider (PCP) office visits	3 $0 copay PCP visits, then 0% coinsurance after deductible
Specialist office visits	0% coinsurance after deductible
Telemedicine	Covered in full after deductible
Hospital admission	0% coinsurance after deductible
Emergency room copay (waived if admitted)	0% coinsurance after deductible
Annual deductible (individual/family)	$8,700/$17,400
Annual out-of-pocket maximum (individual/family)	$8,700/$17,400
Prescription drugs	0% coinsurance after deductible
Inpatient Hospital Services	**Copay/Limitations**
Inpatient physician and surgical services	0% coinsurance after deductible
Semi-private room and board	0% coinsurance after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, x-rays, and lab tests	0% coinsurance after deductible
Short-term speech, physical, occupational, and respiratory therapy (when part of an acute admission)	0% coinsurance after deductible
Speech, physical, occupational, and respiratory therapy (when part of a rehabilitation admission)	0% coinsurance after deductible
Radiation therapy and chemotherapy	0% coinsurance after deductible
Pre-admission testing	0% coinsurance after deductible
Outpatient Medical Care	**Copay/Limitations**
PCP office visits	0% coinsurance after deductible
Specialist office visits	0% coinsurance after deductible
Preventive care* including physical exams, ear exams, health education and counseling, pap smear, mammography, and immunizations	Covered in full
Well-child care*	Covered in full
Diagnostic laboratory services	0% coinsurance after deductible
Prenatal care in physican's office	Covered in full
Ambulatory surgery	0% coinsurance after deductible
Second medical and surgical opinion	0% coinsurance after deductible
Chiropractic services	0% coinsurance after deductible
Mental Health and Substance Use Disorder	**Copay/Limitations**
Mental health care	
Inpatient treatment of mental illness	0% coinsurance after deductible
Outpatient treatment of mental illness	0% coinsurance after deductible
Substance use disorder	
Inpatient detoxification	0% coinsurance after deductible
Inpatient rehabilitation treatment	0% coinsurance after deductible
Outpatient rehabilitation treatment	0% coinsurance after deductible

Summary of Benefits	
Special Kinds of Care	**Copay/Limitations**
Emergency and urgent care	
In hospital emergency room	0% coinsurance after deductible
In urgent care facility	0% coinsurance after deductible
Ambulance service to the hospital	0% coinsurance after deductible
Home health care	0% coinsurance after deductible
Hospice care	0% coinsurance after deductible
Skilled nursing facility care	0% coinsurance after deductible
Dialysis treatment	0% coinsurance after deductible
Diabetes equipment, supplies, and education	0% coinsurance after deductible
Outpatient physical, speech, occupational, and respiratory therapy	0% coinsurance after deductible
Family planning services	Covered in full
Infertility diagnosis and treatment	Covered in full
Durable medical equipment	0% coinsurance after deductible
Hearing aids	0% coinsurance after deductible
Pediatric Dental Benefits	**Copay/Limitations**
Emergency dental care	0% coinsurance after deductible
Preventive dental care (dental exam and cleaning)	0% coinsurance after deductible/1 every 6 months
Routine dental care	0% coinsurance after deductible
Major dental care	0% coinsurance after deductible
Orthodontics	0% coinsurance after deductible
Pediatric Vision Care Benefits	**Copay/Limitations**
Exams	0% coinsurance after deductible/1 every 12 months
Lenses and frames	0% coinsurance after deductible/1 every 12 months
Contact lenses	0% coinsurance after deductible/1 every 12 months

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EmblemHealth Direct Pay Rates

HMO Standard Health Plan Rates

Listed below are the monthly premium rates for EmblemHealth plans by region.

Rates are effective 1/1/2022 through 12/31/2022

		EmblemHealth Platinum	EmblemHealth Gold	EmblemHealth Silver	EmblemHealth Bronze	EmblemHealth Basic
Downstate	Individual	$1,382.80	$1,142.57	$951.01	$723.34	$452.45
	Individual & Spouse	$2,765.60	$2,285.14	$1,902.02	$1,446.68	$904.90
	Parent & Child(ren)	$2,350.76	$1,942.37	$1,616.72	$1,229.68	$769.17
	Family	$3,940.98	$3,256.32	$2,710.38	$2,061.52	$1,289.48
	Child Only	$569.71	$470.74	$391.82	$298.02	N/A
Long Island	Individual	$1,573.07	$1,299.79	$1,081.87	$822.87	$514.71
	Individual & Spouse	$3,146.14	$2,599.58	$2,163.74	$1,645.74	$1,029.42
	Parent & Child(ren)	$2,674.22	$2,209.64	$1,839.18	$1,398.88	$875.01
	Family	$4,483.25	$3,704.40	$3,083.33	$2,345.18	$1,466.92
	Child Only	$648.10	$535.51	$445.73	$399.02	N/A
Albany	Individual	$1,657.23	$1,369.32	$1,139.75	$866.89	$542.24
	Individual & Spouse	$3,314.46	$2,738.64	$2,279.50	$1,733.78	$1,084.48
	Parent & Child(ren)	$2,817.29	$2,327.84	$1,937.58	$1,473.71	$921.81
	Family	$4,723.11	$3,902.56	$3,248.29	$2,470.64	$1,545.38
	Child Only	$682.78	$564.16	$469.58	$357.16	N/A
Mid-Hudson	Individual	$1,657.94	$1,369.91	$1,140.24	$867.26	$542.47
	Individual & Spouse	$3,315.88	$2,739.82	$2,280.48	$1,734.52	$1,084.94
	Parent & Child(ren)	$2,818.50	$2,328.85	$1,938.41	$1,474.34	$922.20
	Family	$4,725.13	$3,904.24	$3,249.68	$2,471.69	$1,546.04
	Child Only	$683.07	$564.40	$469.78	$357.31	N/A
Syracuse	Individual	$1,657.23	$1,369.32	$1,139.75	$866.89	$542.24
	Individual & Spouse	$3,314.46	$2,738.64	$2,279.50	$1,733.78	$1,084.48
	Parent & Child(ren)	$2,817.29	$2,327.84	$1,937.58	$1,473.71	$921.81
	Family	$4,723.11	$3,902.56	$3,248.29	$2,470.64	$1,545.38
	Child Only	$682.78	$564.16	$469.58	$357.16	N/A
Utica/Watertown	Individual	$1,657.23	$1,369.32	$1,139.75	$866.89	$542.24
	Individual & Spouse	$3,314.46	$2,738.64	$2,279.50	$1,733.78	$1,084.48
	Parent & Child(ren)	$2,817.29	$2,327.84	$1,937.58	$1,473.71	$921.81
	Family	$4,723.11	$3,902.56	$3,248.29	$2,470.64	$1,545.38
	Child Only	$682.78	$564.16	$469.58	$357.16	N/A

Listed below are the monthly premium rates with **age 29 rider**, which extends coverage for young adults through age 29 (up to 30th birthday).

		EmblemHealth Platinum Age 29	EmblemHealth Gold Age 29	EmblemHealth Silver Age 29	EmblemHealth Bronze Age 29
Downstate	Individual	$1,424.28	$1,176.85	$979.54	$745.04
	Individual & Spouse	$2,848.56	$2,353.70	$1,959.08	$1,490.08
	Parent & Child(ren)	$2,421.28	$2,000.65	$1,665.22	$1,266.57
	Family	$4,059.20	$3,354.02	$2,791.69	$2,123.36
Long Island	Individual	$1,620.26	$1,338.78	$1,114.33	$847.56
	Individual & Spouse	$3,240.52	$2,677.56	$2,228.66	$1,695.12
	Parent & Child(ren)	$2,754.44	$2,275.93	$1,894.36	$1,440.85
	Family	$4,617.74	$3,815.52	$3,175.84	$2,415.55
Albany	Individual	$1,706.95	$1,410.40	$1,173.94	$892.90
	Individual & Spouse	$3,413.90	$2,820.80	$2,347.88	$1,785.80
	Parent & Child(ren)	$2,901.82	$2,397.68	$1,995.70	$1,517.93
	Family	$4,864.81	$4,019.64	$3,345.73	$2,544.77
Mid-Hudson	Individual	$1,707.68	$1,411.01	$1,174.45	$893.28
	Individual & Spouse	$3,415.36	$2,822.02	$2,348.90	$1,786.56
	Parent & Child(ren)	$2,903.06	$2,398.72	$1,996.57	$1,518.58
	Family	$4,866.89	$4,021.38	$3,347.18	$2,545.85
Syracuse	Individual	$1,706.95	$1,410.40	$1,173.94	$892.90
	Individual & Spouse	$3,413.90	$2,820.80	$2,347.88	$1,785.80
	Parent & Child(ren)	$2,901.82	$2,397.68	$1,995.70	$1,517.93
	Family	$4,864.81	$4,019.64	$3,345.73	$2,544.77
Utica/Watertown	Individual	$1,706.95	$1,410.40	$1,173.94	$892.90
	Individual & Spouse	$3,413.90	$2,820.80	$2,347.88	$1,785.80
	Parent & Child(ren)	$2,901.82	$2,397.68	$1,995.70	$1,517.93
	Family	$4,864.81	$4,019.64	$3,345.73	$2,544.77

Albany: Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schoharie, Schenectady, Warren, Washington
Mid-Hudson: Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster
Downstate: Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester
Syracuse: Broome
Utica/Watertown: Otsego
Long Island: Nassau, Suffolk

HMO Nonstandard Health Plans Rates

Listed below are the monthly premium rates for EmblemHealth plans by region.

Rates are effective 1/1/2022 through 12/31/2022

		EmblemHealth Gold Premium	EmblemHealth Gold Value	EmblemHealth Silver Value	EmblemHealth Silver Bold
Downstate	Individual	$905.08	$887.05	$693.80	$659.05
	Individual & Spouse	$1,810.16	$1,774.10	$1,387.60	$1,318.10
	Parent & Child(ren)	$1,538.64	$1,507.99	$1,179.46	$1,120.39
	Family	$2,579.48	$2,528.09	$1,977.33	$1,878.29
	Child Only	$372.89	$365.46	$285.85	$271.53
Long Island	Individual	$1,029.61	$1,009.11	$789.27	$749.74
	Individual & Spouse	$2,059.22	$2,018.22	$1,578.54	$1,499.48
	Parent & Child(ren)	$1,750.34	$1,715.49	$1,341.76	$1,274.56
	Family	$2,934.39	$2,875.96	$2,249.42	$2,136.76
	Child Only	$424.20	$415.75	$325.18	$308.89
Albany	Individual	$1,084.69	$1,063.09	$831.49	N/A
	Individual & Spouse	$2,169.38	$2,126.18	$1,662.98	N/A
	Parent & Child(ren)	$1,843.97	$1,807.25	$1,413.53	N/A
	Family	$3,091.37	$3,029.81	$2,369.75	N/A
	Child Only	$446.89	$437.99	$342.57	N/A
Mid-Hudson	Individual	$1,085.16	$1,063.55	$831.85	N/A
	Individual & Spouse	$2,170.32	$2,127.10	$1,663.70	N/A
	Parent & Child(ren)	$1,844.77	$1,808.04	$1,414.15	N/A
	Family	$3,092.71	$3,031.12	$2,370.77	N/A
	Child Only	$447.09	$438.18	$342.72	N/A
Syracuse	Individual	$1,084.69	$1,063.09	$831.49	N/A
	Individual & Spouse	$2,169.38	$2,126.18	$1,662.98	N/A
	Parent & Child(ren)	$1,843.97	$1,807.25	$1,413.53	N/A
	Family	$3,091.37	$3,029.81	$2,369.75	N/A
	Child Only	$446.89	$437.99	$342.57	N/A
Utica/Watertown	Individual	$1,084.69	$1,063.09	$831.49	N/A
	Individual & Spouse	$2,169.38	$2,126.18	$1,662.98	N/A
	Parent & Child(ren)	$1,843.97	$1,807.25	$1,413.53	N/A
	Family	$3,091.37	$3,029.81	$2,369.75	N/A
	Child Only	$446.89	$437.99	$342.57	N/A

Listed below are the monthly premium rates with **age 29 rider**, which extends coverage for young adults through age 29 (up to 30th birthday).

		EmblemHealth Gold Premium Age 29	EmblemHealth Gold Value Age 29	EmblemHealth Silver Value Age 29	EmblemHealth Silver Bold Age 29
Downstate	Individual	$932.23	$913.66	$714.61	$678.82
	Individual & Spouse	$1,864.46	$1,827.32	$1,429.22	$1,357.64
	Parent & Child(ren)	$1,584.79	$1,553.22	$1,214.84	$1,153.99
	Family	$2,656.86	$2,603.93	$2,036.64	$1,934.64
Long Island	Individual	$1,060.50	$1,039.38	$812.95	$772.23
	Individual & Spouse	$2,121.00	$2,078.76	$1,625.90	$1,544.46
	Parent & Child(ren)	$1,802.85	$1,766.95	$1,382.02	$1,312.79
	Family	$3,022.43	$2,962.23	$2,316.91	$2,200.86
Albany	Individual	$1,117.23	$1,094.98	$856.43	N/A
	Individual & Spouse	$2,234.46	$2,189.96	$1,712.86	N/A
	Parent & Child(ren)	$1,899.29	$1,861.47	$1,455.93	N/A
	Family	$3,184.11	$3,120.69	$2,440.83	N/A
Mid-Hudson	Individual	$1,117.71	$1,095.46	$856.81	N/A
	Individual & Spouse	$2,235.42	$2,190.92	$1,713.62	N/A
	Parent & Child(ren)	$1,900.11	$1,862.28	$1,456.58	N/A
	Family	$3,185.47	$3,122.06	$2,441.91	N/A
Syracuse	Individual	$1,117.23	$1,094.98	$856.43	N/A
	Individual & Spouse	$2,234.46	$2,189.96	$1,712.86	N/A
	Parent & Child(ren)	$1,899.29	$1,861.47	$1,455.93	N/A
	Family	$3,184.11	$3,120.69	$2,440.83	N/A
Utica/Watertown	Individual	$1,117.23	$1,094.98	$856.43	N/A
	Individual & Spouse	$2,234.46	$2,189.96	$1,712.86	N/A
	Parent & Child(ren)	$1,899.29	$1,861.47	$1,455.93	N/A
	Family	$3,184.11	$3,120.69	$2,440.83	N/A

Albany: Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schoharie, Schenectady, Warren, Washington
Mid-Hudson: Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster
Downstate: Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester
Syracuse: Broome
Utica/Watertown: Otsego
Long Island: Nassau, Suffolk

EmblemHealth

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 (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**)。

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

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يرجى الانتباه: تتوفر لك خدمات المساعدة اللغوية مجانا، 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)
وجہ 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)
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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

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