EmblemHealth

Coverage Period: Begins on or after 01/01/2022

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

EmblemHealth : EmblemHealth Gold Premier-M **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 1-888-447-8255. 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 www.emblemhealth.com or call 1-888-447-8255 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$450 Individual / $900 Family in network providers. Does not apply to preventive care.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Primary care office visits, preventive care, prenatal care, and telemedicine are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Prescription Drugs: $0	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in network providers $6,000 Individual / $12,000 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, penalties, balanced-bill 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 an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). **Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.**
Do you need a referral to see a specialist?	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
		Network Provider (You will pay the least)	Out-of-Network 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	First 3 visits (combined), No charge. Thereafter, $25 co-pay per visit not subject to deductible	Not covered	Primary care visits not subject to Plan deductible. Any combination of PCP, ABA, MH/SUD.
	Specialist visit	$40 co-pay per visit not subject to deductible	Not covered	Specialist visit not subject to Plan deductible. Referral required. Failure to obtain Referral will result in a denial of payment or reduced payment.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your Plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: $25/$40 co-pay per visit not subject to deductible X-ray: After Plan deductible is met, $25/$40 co-pay per visit	Not covered	Referral required for Diagnostic Testing performed in Specialist Office. Prior Approval required for Outpatient Diagnostic Testing and Lab Procedures Failure to obtain Prior Approval or Referral will result in denial of payment or reduced payment.
	Imaging (CT/PET scans, MRIs)	After Plan deductible is met, $40 co-pay per visit	Not covered	Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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)	Retail: $0 co-pay/30 day supply Mail Order: $0 co-pay/90 day supply	Not covered	If you have an emergency condition, Prior Approval 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. Ancillary charges apply, per your Member Contract. 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 which excludes CVS.
	Preferred brand drugs (Tier 2)	Retail: $40 co-pay/30 day supply Mail Order: $100 co-pay/90 day supply	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: $80 co-pay/30 day supply Mail Order: $200 co-pay/90 day supply	Not covered	
	Specialty drugs	Tier 1: $0 co-pay/30 day supply Tier 2: $40 co-pay/30 day supply Tier 3: $80 co-pay/30 day supply	Not covered	Must be dispensed by a Specialty Pharmacy. Written referral required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	After Plan deductible is met, $350 co-pay per visit	Not covered	Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.
	Physician/surgeon fees	After Plan deductible is met, $350 co-pay per visit	Not covered	Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.
If you need immediate medical attention	Emergency room care	After Plan deductible is met, $800 co-pay per visit	After Plan deductible is met, $800 co-pay per visit	Waived if admitted.
	Emergency medical transportation	After Plan deductible is met, $350 co-pay per visit	After Plan deductible is met, $350 co-pay per visit	-----None-----
	Urgent care	$75 co-pay per visit not subject to deductible	Not covered	Urgent care not subject to Plan deductible. In network only
If you have a hospital stay	Facility fee (e.g., hospital room)	After Plan deductible is met, 30% coinsurance per admission	Not covered	Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment. However, Prior Approval is not Required for emergency admissions.
	Physician/surgeon fee	After Plan deductible is met, $350 co-pay per visit	Not covered	Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	First 3 visits (combined), No charge. Thereafter, $25 co-pay per visit not subject to deductible	Not covered	Unlimited visits. For Substance Abuse care, up to twenty (20) visits per plan year may be used for family counseling.
	Inpatient services	After Plan deductible is met, 30% coinsurance per admission	Not covered	Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment. However, Prior Approval is not required 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	After Plan deductible is met, $350 co-pay per visit	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Depending on the type of service, a copayment, coinsurance or deductible may apply. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.
	Childbirth/delivery facility services	After Plan deductible is met, 30% coinsurance per admission	Not covered	Limited to forty-eight (48) hours for natural delivery and ninety-six (96) hours for caesarean delivery. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment. Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC.

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	After Plan deductible is met, $40 co-pay per visit	Not covered	Forty (40) visits per plan year. Home infusion counts toward home health care visit limits. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.
	Rehabilitation services	After Plan deductible is met, Outpatient: $25/$40 co-pay per visit Inpatient: 30% coinsurance per admission	Not covered	Inpatient: Sixty (60) days per plan year. Combined therapies. Outpatient: Sixty (60) visits per condition per plan year. Combined therapies. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment
	Habilitation services	After Plan deductible is met, Outpatient: $25/$40 co-pay per visit Inpatient: 30% coinsurance per admission	Not covered	
	Skilled nursing care	After Plan deductible is met, 30% coinsurance per admission	Not covered	200 days per plan year. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.
	Durable medical equipment	After Plan deductible is met, 20% coinsurance	Not covered	One (1) external prosthetic device per limb per lifetime. No orthotics. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.
	Hospice services	After Plan deductible is met, Outpatient: $40 co-pay per visit Inpatient: 30% coinsurance	Not covered	210 days per plan year. Five (5) visits for family bereavement counseling. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Children's eye exam not subject to Plan deductible. One (1) exam per twelve (12)-month period
	Children's glasses	20% coinsurance not subject to deductible	Not covered	Children's glasses not subject to Plan deductible. One (1) prescribed lenses and frames per twelve (12)-month period
	Children's dental check-up	$25 co-pay per visit not subject to deductible	Not covered	Children's dental check-up not subject to Plan deductible. One (1) dental exam & cleaning per six (6)-month period. Full mouth X-rays or panoramic X-rays at thirty-six (36)-month intervals and bitewing X-rays at six (6)-month intervals

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
- Cosmetic surgery
- Adult Dental care
- Long-term care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion services
- Bariatric surgery (Prior Approval required)
- Chiropractic care
- Hearing aids (Prior Approval required)
- Infertility treatment (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 right, 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 Bureau of Consumer Services – Complaint Unit Corning Tower – OCP Room 1607 Albany, NY 12237 Email: managedcarecomplaint@health.ny.gov Website: www.health.ny.gov	**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 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
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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.

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** $450
- **Specialist (cost sharing)** $40
- **Hospital (facility) cost sharing** $0
- **Other cost sharing**

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	$12,800

In the example, Peg would pay:

Cost Sharing	
Deductibles	$450
Copayments	$1,160
Coinsurance	$3,406
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,976

Managing Joe's type 2 diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $450
- **Specialist (cost sharing)** $40
- **Hospital (facility) cost sharing** $0
- **Other cost sharing**

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	$7,400

In the example, Joe would pay:

Cost Sharing	
Deductibles	$450
Copayments	$2,440
Coinsurance	$346
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$3,191

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $450
- **Specialist (cost sharing)** $40
- **Hospital (facility) cost sharing** $0
- **Other cost sharing**

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	$1,900

In the example, Mia would pay:

Cost Sharing	
Deductibles	$450
Copayments	$1,680
Co-insurance	$18
What isn't covered	
Limits or exclusions	
The total Mia would pay is	$2,048

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

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 (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**).

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

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

(Urdu) اردو
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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