

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
EmblemHealth : Essential Plan 2 Plus
Coverage for: Individual

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 ?	\$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 ?	Yes. 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For in network providers \$200 for an Individual	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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (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	No charge	Not covered	----None----
	Specialist visit	No charge	Not covered	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)	No charge	Not covered	Referral required for services performed in Specialist Office and Outpatient Hospital. Failure to obtain referral will result in denial of payment or reduced payment.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Referral required. Failure to obtain Referral will result in denial of payment or reduced payment.
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: \$1 co-pay/30 day supply Mail Order: \$2.50 co-pay/90 day supply	Not covered	Prescription drugs not subject to Plan deductible. If you have an emergency condition, Prior Approval is not required for a five (5) day emergency supply of 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. Must be dispensed by a Participating Pharmacy.
	Preferred brand drugs (Tier 2)	Retail: \$3 co-pay/30 day supply Mail Order: \$7.50 co-pay/90 day supply	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: \$3 co-pay/30 day supply Mail Order: \$7.50 co-pay/90 day supply	Not covered	
	Specialty drugs (Tier 4)	Tier 1: \$1 co-pay/30 day supply Tier 2: \$3 co-pay/30 day supply Tier 3: \$3 co-pay/30 day supply	Not covered	Must be dispensed by a Specialty Pharmacy. Written referral required.

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

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.
	Physician/surgeon fees	No charge	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	No charge	No charge	Waived if admitted.
	Emergency medical transportation	No charge	No charge	-----None-----
	Urgent care	No charge	Not covered	In network only
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	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	No charge	Not covered	Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	No charge	Not covered	Unlimited visits. For Substance Abuse care, up to twenty (20) visits per plan year may be used for family counseling.
	Inpatient services	No charge	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.

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

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
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	No charge	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	No charge	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.

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

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	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	No charge	Not covered	Inpatient: Sixty (60) days per plan year. Combined therapies.
	Habilitation services	No charge	Not covered	Outpatient: Sixty (60) visits per condition per plan year. Combined therapies. Speech and physical therapy are only covered following a hospital stay or surgery. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment
	Skilled nursing care	No charge	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	No charge	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	No charge	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.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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

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 | • Private-duty nursing |
| • Cosmetic surgery | • Most coverage provided outside the United States | • Routine foot care |
| | • Non-emergency care when traveling outside the U.S. | • 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 | • Hearing aids (Prior Approval required) | • Routine eye care (Adult) |
| • Bariatric surgery (Prior Approval required) | • Infertility treatment (Prior Approval required) | |
| • Chiropractic care | | |
| • Dental care (Adult) | | |

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 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

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

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.

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, kwijigo 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](#) \$0
- [Specialist](#) (cost sharing) \$0
- Hospital (facility) [cost sharing](#) \$0
- Other [cost sharing](#) \$60

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
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In the example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$4
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$64

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](#) (cost sharing) \$0
- Hospital (facility) [cost sharing](#) \$0
- Other [cost sharing](#) \$55

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
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In the example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$70
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$125

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) (cost sharing) \$0
- Hospital (facility) [cost sharing](#) \$0
- Other [cost sharing](#) \$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	\$1,900
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In the example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Co-insurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$0

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



GETTING HELP IN A LANGUAGE OTHER THAN ENGLISH

Getting Help in a Language Other than English

ATTENTION: This is an important document. If you need help to understand it, please call the telephone number marked “customer service” on the back of your member ID card [TTY/TDD: 711]. We can give you an interpreter for free in the language you speak.

Español (Spanish)

ATENCIÓN: Este es un documento importante. Si necesita ayuda para entenderlo, llame al número telefónico marcado “customer service” que se encuentra en el dorso de su tarjeta de identificación de miembro [TTY/TDD: 711]. Le podemos proporcionar un intérprete que habla su idioma sin ningún costo.

中文 (Traditional Chinese)

注意：這是重要的文件。如果您需要協助來瞭解文件內容，請致電您會員卡背面標記為“customer service”的電話號碼[TTY/TDD：711]。我們可以為您免費提供您所使用語言的翻譯人員。

Русский (Russian)

ВНИМАНИЕ! Это важный документ. Если у Вас возникли трудности с пониманием этого документа и Вам необходима помощь, позвоните по телефону отдела обслуживания клиентов (customer service), указанному на обратной стороне Вашей идентификационной карточки [служба текстового телефона (TTY/TDD): 711]. Мы можем бесплатно предоставить Вам переводчика, который говорит на Вашем языке.

Kreyòl Ayisyen (Haitian Creole)

ATANSYON: Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo ki make “customer service” nan do kat ID manm ou [TTY/TDD: 711]. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

한국어 (Korean)

주의: 이것은 중요한 문서입니다. 이 문서를 이해하는 데 도움이 필요하시면 회원 ID 카드의 뒷면에 “customer service” 라고 표시된 전화번호 [TTY/TDD: 711]로 연락해 주십시오. 저희는 귀하가 사용하는 언어에 대해 무료 통역사를 제공할 수 있습니다.

Italiano (Italian)

ATTENZIONE. Questo è un documento importante. Per qualsiasi chiarimento telefoni all “customer service” al numero stampato sul retro della Sua tessera (per i non udenti: 711). Possiamo mettere a disposizione gratis un interprete nella Sua lingua.

אײַדיש (Yiddish)

מעלדונג: דאס איז א וויכטיגע דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט דעם טעלעפון נומבער גערופן “customer service” אויף אייער קארטל [TTY/TDD: 711]. מיר קענען אייך געבן אן איבערזעצער פריי אין די שפראך וואס איר רעדט.

বাংলা (Bengali)

দৃষ্টি আকর্ষণ করছি: এটি একটি গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয়, তাহলে অনুগ্রহ করে আপনার মেম্বার আইডি কার্ডের উল্টোপাঠে "customer service" চিহ্নিত টেলিফোন নম্বরে [TTY/TDD: 711] কল করুন। আপনি যে ভাষায় কথা বলেন সে-ভাষার জন্য বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

Polski (Polish)

UWAGA: To jest ważny dokument. Jeżeli potrzebujesz pomocy w celu zrozumienia jego treści, zadzwoń do „customer service” pod numer telefonu podany na odwrocie karty identyfikacyjnej ubezpieczonego (member ID card) [TTY/TDD: 711]. Możemy bezpłatnie zapewnić usługi tłumacza języka, którym się posługujesz.

العربية (ARABIC)

انتباه: هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم المشار إليه بـ "customer service" على ظهر بطاقة عضويتك [711:TTY/TDD]. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجاناً.

Français (French)

ATTENTION : ce document est important. Si vous avez besoin d'aide pour en comprendre le contenu, veuillez composer le numéro «customer service » au dos de votre carte de membre [Sourds et malentendants : 711]. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

اردو (Urdu)

توجہ دیں: یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم "customer service" والے نمبر پر کال کریں جو آپ کے ممبر آئی ڈی کارڈ کی پشت پر درج ہے [ٹی ٹی وائی/ٹی ڈی ڈی: 711]۔ آپ جو زبان بولتے ہیں اس میں ہم آپ کو مفت مترجم فراہم کرسکتے ہیں۔

Tagalog (Tagalog)

NANAWAGAN NG PANSIN: Ito ay isang mahalagang dokumento. Kung kailangan mo ng tulong para maintindihan ito, pakitawagan ang numero ng telepono na minarkahang "customer service" sa likod ng inyong ID card ng miyembro [TTY/TDD: 711]. Maaari ka naming bigyan ng libreng interpreter sa wikang iyong sinasalita.

Ελληνικά (Greek)

ΠΡΟΣΟΧΗ: Αυτό το έγγραφο είναι σημαντικό. Εάν χρειάζεστε βοήθεια για να το κατανοήσετε, καλέστε μας στον αριθμό που σημειώνεται ως «customer service» στο πίσω μέρος της κάρτας της συνδρομής σας [αριθμός για άτομα με προβλήματα ακοής (TTY/TDD): 711]. Μπορούμε να σας προσφέρουμε δωρεάν διερμηνεία στη μητρική σας γλώσσα.

Shqip (Albanian)

VINI RE: Ky është një dokument i rëndësishëm. Nëse ju nevojitet ndihmë për ta kuptuar, ju lutemi telefononi në numrin ku shkruhet "customer service", i cili gjendet ne anen e pasme të kartës tuaj identifikuese të anëtarësisë [Shërbimi rele TTY/TDD: 711]. Ne mund t'ju ofrojmë pa pagesë një përkthyes në gjuhën që flisni ju.

NOTICE OF NONDISCRIMINATION POLICY

EmblemHealth complies with applicable 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 communicate effectively with us, such as: -
Qualified sign language interpreters - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please call the telephone number marked “customer service” on the back of your member ID card.
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 the telephone number marked “customer service” on the back of your member ID card. (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.