

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

Plan Type: HMO


The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-624-2414. 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 1-800-624-2414 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$3,000 Individual / \$6,000 Family in network providers.	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. In network preventive care, primary care services, and maternity care services 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, accumulates plan year, \$100 Individual / \$200 Family for prescription drugs.	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 \$7,150 Individual / \$14,300 Family. Accumulates plan year.	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 in the Prime Network.	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, written approval is required to see a specialist.	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	\$30 co-pay visit	Not covered	Not subject to Plan deductible
	Specialist visit	After Plan deductible is met, \$60 co-pay visit	Not covered	Referral required
	Preventive care/screening/immunization	No charge	Not covered	Applies to most services in accordance with USPSTF and HRSA including: Well Child Visits; Adult Annual Physical Exams; Well Woman Exams; Bone Density Testing.
If you have a test	Diagnostic test (x-ray, blood work)	PCP office: \$30 co-pay visit SCP office: After Plan deductible is met, \$60 co-pay visit	Not covered	When service performed in Specialist (SCP) office, referral required
	Imaging (CT/PET scans, MRIs)	After Plan deductible is met, \$60 co-pay visit	Not covered	Referral required

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: \$25 co-pay/30 day supply Mail Order: \$62.50 co-pay/90 day supply	Not covered	Tier 1, Tier 2 and Tier 3 drugs are covered and subject to annual Rx deductible of \$100 Individual / \$200 Family before copay applies.
	Preferred brand drugs (Tier 2)	Retail: \$50 co-pay/30 day supply Mail Order: \$125 co-pay/90 day supply	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: \$100 co-pay/30 day supply Mail Order: \$250 co-pay/90 day supply	Not covered	
	Specialty drugs	Tier 1: \$25 co-pay/30 day supply Tier 2: \$50 co-pay/30 day supply Tier 3: \$100 co-pay/30 day supply	Not covered	Subject to annual Rx deductible before copay applies. Written referral required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Facility: After Plan deductible is met, \$200 co-pay visit Outpatient Hospital Facility: After Plan deductible is met, \$500 co-pay visit	Not covered	Preauthorization required
	Physician/surgeon fees	After Plan deductible is met, No charge	Not covered	Preauthorization required

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 immediate medical attention	Emergency room care	After Plan deductible is met, \$150 co-pay visit	After Plan deductible is met, \$150 co-pay visit	Applies to facility charge, waived if admitted.
	Emergency medical transportation	After Plan deductible is met, \$150 co-pay visit	After Plan deductible is met, \$150 co-pay visit	-----None-----
	Urgent care	After Plan deductible is met, \$75 co-pay visit	Not covered	Applies to facility charge
If you have a hospital stay	Facility fee (e.g., hospital room)	After Plan deductible is met, \$500 per admission	Not covered	Preauthorization required
	Physician/surgeon fee	After Plan deductible is met, No charge	Not covered	Preauthorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 co-pay visit	Not covered	Not subject to Plan deductible and unlimited visits. For Substance Abuse care, up to 20 visits per plan year may be used for family counseling
	Inpatient services	After Plan deductible is met, \$500 per admission	Not covered	Preauthorization required However, Preauthorization is not required for emergency admissions.
If you are pregnant	Office visits	\$30 co-pay visit	Not covered	Not subject to Plan deductible Pre/Postnatal Care provided in accordance with USPSTF and HRSA has No charge.
	Childbirth/delivery professional services	No charge	Not covered	Not subject to Plan deductible
	Childbirth/delivery facility services	\$1,000 co-pay	Not covered	Not subject to Plan deductible Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Preauthorization required

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, \$60 co-pay visit	Not covered	40 visits per plan year. Preauthorization required
	Rehabilitation services	Inpatient: After Plan deductible is met, \$500 per admission Outpatient: After Plan deductible is met, \$60 co-pay visit	Not covered	Inpatient: Rehab.-30 days, combined therapies. Hab.-30 days, combined therapies. Per plan year. Preauth. required.
	Habilitation services	Inpatient: After Plan deductible is met, \$500 per admission Outpatient: After Plan deductible is met, \$60 co-pay visit	Not covered	Outpatient: Rehab.-90 visits, combined therapies. Hab.-90 visits, combined therapies. Per plan year. Preauth. required.
	Skilled nursing care	After Plan deductible is met, No charge	Not covered	90 days per plan year. Preauthorization required
	Durable medical equipment	No charge	Not covered	Preauthorization required
	Hospice services	After Plan deductible is met, No charge	Not covered	210 days per plan year. Preauthorization required
If your child needs dental or eye care	Children's eye exam	After Plan deductible is met, \$60 co-pay visit	Not covered	Refractive eye exam. Referral required
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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](#).)

- | | | |
|--------------------|--|------------------------|
| • Cosmetic surgery | • Hearing aids | • Private-duty nursing |
| • Dental care | • Long-term care | • Routine eye care |
| | • 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.)

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|---|---|
| • Acupuncture | • Infertility treatment (Prior Approval required) |
| • Bariatric surgery (Prior Approval required) | |
| • Chiropractic 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.

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 on how 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



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	\$3,000
■ Specialist (cost sharing)	\$60
■ Hospital (facility) cost sharing	\$1,000
■ 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	\$12,700
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In the example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$1,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,560

Managing Joe's type 2 diabetes

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

■ The plan's overall deductible	\$3,000
■ Specialist (cost sharing)	\$60
■ Hospital (facility) cost sharing	\$500
■ Other cost sharing	\$20

This EXAMPLE event includes services

like: [Primary care physician](#) office visits (including disease education)
[Diagnostic tests](#) (blood work)
[Prescription drugs](#)
[Durable medical equipment](#) (glucose meter)

Total Example Cost	\$5,600
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In the example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,000
■ Specialist (cost sharing)	\$60
■ Hospital (facility) cost sharing	\$200
■ 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	\$2,800
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In the example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,200
Copayments	\$0
Co-insurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,200