EmblemHealth®

Coverage Period: 7/1/2021 - 6/30/2022

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

EmblemHealth : HIP Prime POS **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?	$0, in network providers, $750 Individual / $2,250 Family out of 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?	In network medical and hospital services are not subject to a deductible. All covered out of network services, except emergency care, are subject to a 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?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
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, 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	$10 co-pay visit	After Plan deductible is met, 30% coinsurance	-----None-----
	Specialist visit	$15 co-pay visit	After Plan deductible is met, 30% coinsurance	-----None-----
	Preventive care/screening/ immunization	No charge	After Plan deductible is met, 30% coinsurance	Applies to Well Child Visits; Adult Annual Physical Exams; Well Woman Exams; Bone Density Testing.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	After Plan deductible is met, 30% coinsurance	-----None-----
	Imaging (CT/PET scans, MRIs)	No charge	After Plan deductible is met, 30% coinsurance	Preauthorization required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.EmblemHealth.com.	Generic drugs (Tier 1)	Not covered	Not covered	
	Preferred brand drugs (Tier 2)	Not covered	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 co-pay	After Plan deductible is met, 30% coinsurance	Preauthorization required
	Physician/surgeon fees	No charge	After Plan deductible is met, 30% coinsurance	-----None-----
If you need immediate medical attention	Emergency room care	$100 co-pay	$100 co-pay	Applies to facility charge, waived if admitted.
	Emergency medical transportation	No charge	No charge	-----None-----
	Urgent care	$10 co-pay visit	After Plan deductible is met, 0% coinsurance	Applies to facility charge.

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 a hospital stay	Facility fee (e.g., hospital room)	$100 per admission	After Plan deductible is met, 30% coinsurance	Preauthorization required
	Physician/surgeon fee	No charge	After Plan deductible is met, 30% coinsurance	-----None-----
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$10 co-pay visit	After Plan deductible is met, 30% coinsurance	Unlimited visits. For Substance Abuse care, up to 20 visits per calendar year may be used for family counseling
	Inpatient services	$100 per admission	After Plan deductible is met, 30% coinsurance	Preauthorization required. However, Preauthorization is not required for emergency admissions.
If you are pregnant	Office visits	No charge	After Plan deductible is met, 30% coinsurance	-----None-----
	Childbirth/delivery professional services	No charge	After Plan deductible is met, 30% coinsurance	-----None-----
	Childbirth/delivery facility services	$100 per admission	After Plan deductible is met, 30% coinsurance	Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Preauthorization required
If you need help recovering or have other special health needs	Home health care	No charge	After Plan deductible is met, 30% coinsurance	200 visits per calendar year. Preauthorization required.
	Rehabilitation services	Inpatient: $100 per admission Outpatient: $15 co-pay visit	After Plan deductible is met, 30% coinsurance	Inpatient: 90 days per calendar year combined therapies. Preauthorization required. Outpatient: 90 visits per calendar year combined therapies. Preauthorization required.
	Habilitation services	Inpatient: $100 per admission Outpatient: $15 co-pay visit	After Plan deductible is met, 30% coinsurance	
	Skilled nursing care	No charge	Not covered	Unlimited days. Preauthorization required.
	Durable medical equipment	No charge	Not covered	Preauthorization required
	Hospice services	No charge	Not covered	210 days per lifetime. 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 your child needs dental or eye care	Children's eye exam	No charge	After Plan deductible is met, 30% coinsurance	Refractive eye exam
	Children's glasses	Frames: $80 allowance; Standard single, bifocal or trifocal lenses: $35 co-pay	Not covered	Available every 24 months through participating EyeMed/ CPS providers
	Children's dental check-up	$5 co-pay/visit	Not covered	One oral exam every six months

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
- Dental care
- Hearing aids
- Long-term care
- Most coverage provided outside the United States. See www.emblemhealth.com
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Private-duty nursing
- 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 options may be available to you too, including buying individual or SHOP 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	**For All Coverage Types**
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	**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:

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-2414

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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)	$15
Hospital (facility) cost sharing	$100
Other cost sharing	$96

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	$0
Copayments	$305
Coinsurance	$0
What isn't covered	
Limits or exclusions	$96
The total Peg would pay is	$401

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)	$15
Hospital (facility) cost sharing	$100
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

In the example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$780
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$835

Mia's Simple Fracture

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

The plan's overall deductible	$0
Specialist (cost sharing)	$15
Hospital (facility) cost sharing	$100
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

In the example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$220
Co-insurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$220

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

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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.

אידיש (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 উল্টোপিঠে "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.

(ARABIC) العربية

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

Francais (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.

(Urdu)اردو

توجہ دیں: یہ ایک اہم دستاویزہے۔ 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.**