EmblemHealth®

Coverage Period: 01/01/2025 - 12/31/2025

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

EmblemHealth : EmblemHealth HMO **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	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	In network medical and hospital services are not 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?	For in network providers $6,850 Individual / $13,700 Family. Accumulates calendar 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. A referral is required to see a specialty care provider (SCP).	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	$5 co-pay visit	Not covered	-----None-----
	Specialist visit	$10 co-pay visit	Not covered	-----None-----
	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)	Freestanding Facility: No charge Outpatient Hospital: No charge	Not covered	Some services may require preauthorization. Please discuss with your EmblemHealth Participating Physician.
	Imaging (CT/PET scans, MRIs)	Freestanding Facility: No charge Outpatient Hospital: No charge	Not covered	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)	Retail: $5 co-pay/30 day supply Mail Order: $7.50 co-pay/90 day supply	Not covered	Tier 1 and Tier 2 drugs are covered.
	Preferred brand drugs (Tier 2)	Retail: $20 co-pay/30 day supply Mail Order: $30 co-pay/90 day supply	Not covered	
	Non-preferred brand drugs (Tier 3)	Not Covered	Not covered	
	Specialty drugs	Tier 1: $5 co-pay/30 day supply Tier 2: $20 co-pay/30 day supply Tier 3: Not Covered	Not covered	Written referral required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Facility: No charge Outpatient Facility: No charge	Not covered	Preauthorization required
	Physician/surgeon fees	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	$75 co-pay visit	$75 co-pay visit	Applies to facility charge, waived if admitted.
	Emergency medical transportation	No charge	No charge	-----None-----
	Urgent care	$25 co-pay visit	Not covered	Applies to facility charge.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization required
	Physician/surgeon fee	No charge	Not covered	Preauthorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental & Behavioral Health: No charge Substance Abuse: $5 co-pay visit	Not covered	Unlimited visits. For Substance Abuse care, up to 20 visits per calendar year may be used for family counseling
	Inpatient services	No charge	Not covered	Preauthorization required. However, Preauthorization is not required for emergency admissions.
If you are pregnant	Office visits	$5 co-pay visit	Not covered	Pre/Postnatal Care provided in accordance with USPSTF and HRSA has No charge.
	Childbirth/delivery professional services	No charge	After Plan deductible is met, No charge	Preauthorization required
	Childbirth/delivery facility services	No charge	Not covered	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	No charge	Not covered	200 visits per calendar year. Preauthorization required.
	Rehabilitation services	Inpatient: No charge SCP office: $10 co-pay visit	Not covered	Inpatient: Rehab.- 30 days, combined therapies. Hab.- 30 days, combined therapies. Per calendar year. Preauth. required. Outpatient: Rehab.- 90 visits, combined therapies. Hab.- 90 visits, combined therapies. Per calendar year. Preauth. required.
	Habilitation services	Inpatient: No charge SCP office: $10 co-pay visit	Not covered	
	Skilled nursing care	No charge	Not covered	Unlimited days per calendar year. Preauthorization required.
	Durable medical equipment	No charge	Not covered	
	Hospice services	No charge	Not covered	210 days per calendar year. Preauthorization required.
If your child needs dental or eye care	Children's eye exam	$10 co-pay visit	Not covered	One refractive eye exam
	Children's glasses	Frames: $80 allowance; Standard single, bifocal or trifocal lenses: $35 co-pay	Not covered	Available every 24 months, calendar year, through participating EyeMed/ CPS providers
	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.)

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

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

For HMO Coverage	Consumer Assistance Program
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	**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**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 1-800-624-2414
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-2414
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-624-2414
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 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)** $10
- **Hospital (facility) cost sharing** $0
- **Other cost sharing** $61

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

In the example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$9
Coinsurance	$0
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	$70

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)** $10
- **Hospital (facility) cost sharing** $0
- **Other cost sharing** $23

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

In the example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$236
Coinsurance	$0
What isn't covered	
Limits or exclusions	$23
The total Joe would pay is	$259

Mia's Simple Fracture

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

- **The plan's overall deductible** $0
- **Specialist (cost sharing)** $10
- **Hospital (facility) cost sharing** $0
- **Other cost sharing** $248

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

In the example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$150
Co-insurance	$0
What isn't covered	
Limits or exclusions	$248
The total Mia would pay is	$398

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