EmblemHealth Gold Premier
Summary of Benefits
Select Care Network - No Referral Required

PPGLDS004 / MS001009

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Plan deductible	$500 $1,000	$6,000 $12,000
Separate Prescription Drug Deductible	$150 $300	Not Applicable Not Applicable
Out-of-Pocket Maximum	$8,650 $17,300	$12,000 $24,000
Benefits	**In-Network (INET) Member Pays**	**Out-of-network (OON) Member Pays**
Provider Office Visits		
Mental Health and Substance Abuse Office Visits First 3 In-Network visits (any combination of PCP, ABA, MH/SUD) covered in full.	Thereafter, Office Visits: $25 copayment not subject to deductible All Other Outpatient Services: $25 copayment not subject to deductible	50% coinsurance after deductible
ABA Treatment for Autism Spectrum Disorder First 3 In-Network visits (any combination of PCP, ABA, MH/SUD) covered in full. Preauthorization required.	Thereafter, $25 copayment not subject to deductible	50% coinsurance after deductible
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations) First 3 In-Network visits (any combination of PCP, ABA, MH/SUD) covered in full.	Thereafter, $25 copayment not subject to deductible	50% coinsurance after deductible
Specialist Office Visits	$50 copayment not subject to deductible	50% coinsurance after deductible
Telemedicine Services	No Charge	Not Covered
Preventive Office Visits		
Adult/Pediatric Preventive Visits	No Charge	50% coinsurance after deductible
Prenatal Care	No Charge	50% coinsurance after deductible

This EmblemHealth Plan is underwritten by Health Insurance Plan of Greater New York (HIP). The above benefits and services do not require referrals by a Select Care network primary care physician. Preauthorization will still be required for noted benefits.

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Routine Gynecological Services/Well Woman Exams, Mammography Screenings*	No Charge	50% coinsurance after deductible
Well-Baby and Well-Child Care, including Immunizations*	No Charge	50% coinsurance after deductible
***When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF or HRSA**	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)
Vasectomy	See surgical services	See surgical services
All other preventive services*	No Charge	50% coinsurance after deductible
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI) Preauthorization required.	Performed in a Freestanding Facility or Specialist Office: $50 copayment after deductible Performed in an Outpatient Facility: $175 copayment after deductible	50% coinsurance after deductible
Laboratory Services Preauthorization required.	Performed in a PCP Office: $25 copayment not subject to deductible Performed in a Freestanding Facility: $15 copayment not subject to deductible Performed in a Specialist Office: $50 copayment after deductible Performed in an Outpatient Facility: $150 copayment after deductible	50% coinsurance after deductible
Non-Advanced Radiology (X-ray, Diagnostic) Preauthorization may be required.	Performed in a PCP Office: $25 copayment after deductible Performed in a Freestanding Facility: $15 copayment after deductible Performed in a Specialist Office: $50 copayment after deductible Performed in an Outpatient Facility: $150 copayment after deductible	50% coinsurance after deductible
Preadmission Testing Preauthorization required.	$0 copayment after deductible	50% coinsurance after deductible
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$50 copayment after deductible	50% coinsurance after deductible

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Prescription Drugs – Retail Pharmacy (cost-share based on 30-day supply per prescription) Preauthorization 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.		
Preferred Generic Tier 1	$7 copayment not subject to deductible	Not Covered
Non-preferred Generic Tier 2	$40 copayment after deductible	Not Covered
Preferred Brand Tier 3	$85 copayment after deductible	Not Covered
Prescription – Mail Order Pharmacy (up to a 90-day supply per prescription)		
Preferred Generic Tier 1	$17.50 copayment not subject to deductible	Not Covered
Non-preferred Generic Tier 2	$100 copayment after deductible	Not Covered
Preferred Brand Tier 3	$212.50 copayment after deductible	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Physical and Occupational Therapy 60 visits per condition/plan year, combined therapies.	Performed in a PCP Office: $25 copayment after deductible Performed in a Specialist Office: $50 copayment after deductible	Not Covered
Other Services		
Anesthesia Services	No Charge	50% coinsurance after deductible
Cardiac and Pulmonary Rehabilitation Preauthorization required for Inpatient services.	$100 copayment after deductible	50% coinsurance after deductible
Chemotherapy	Performed in a PCP Office: $25 copayment after deductible Performed in a Specialist Office: $65 copayment after deductible Performed in an Outpatient Facility: $100 copayment after deductible	50% coinsurance after deductible
Chiropractic Services	$50 copayment not subject to deductible	50% coinsurance after deductible
Diabetic Equipment and Supplies 90-day supply mail order available In-Network. Preauthorization may be required.	$25 copayment not subject to deductible, per 30-day supply. Insulin covered in full.	50% coinsurance after deductible

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Dialysis	Performed in a PCP Office: $25 copayment after deductible Performed in a Specialist Office: $50 copayment after deductible	50% coinsurance after deductible
Durable Medical Equipment Preauthorization required.	20% coinsurance after deductible	Not Covered
External Hearing Aids Single purchase once every 3 years. Preauthorization required.	20% coinsurance after deductible	Not Covered
Home Health Care 40 visits per plan year. Preauthorization required.	$50 copayment after deductible	50% coinsurance after deductible
Outpatient Services (in a hospital or ambulatory facility) Preauthorization may be required.	$350 copayment after deductible	50% coinsurance after deductible
Inpatient Services		
Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility and all IP settings Preauthorization required, except for emergency admissions.	30% coinsurance after deductible, per admission	50% coinsurance after deductible (Hospice and Skilled Nursing not covered)
Inpatient Rehabilitation Services 60 days per condition/plan year, combined therapies. Preauthorization required.	30% coinsurance after deductible, per admission	Not Covered
Inpatient Habilitation Services 60 days per condition/plan year, combined therapies. Preauthorization required.	30% coinsurance after deductible, per admission	Not Covered
Emergency and Urgent Care		
Ambulance Services	$350 copayment after deductible	$350 copayment after deductible
Emergency Room Waived if admitted to Hospital.	40% coinsurance after deductible	40% coinsurance after deductible
Urgent Care Centers	$100 copayment after deductible	50% coinsurance after deductible
Pediatric Dental Care - up to age 19 end of month		
Preventive Dental Care 1 dental exam and cleaning per 6-month period.	No Charge	Not Covered

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Routine Dental Care Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at 6-month intervals.	$25 copayment not subject to deductible	Not Covered
Major Dental Care Preauthorization required.	$50 copayment after deductible	Not Covered
Orthodontia Preauthorization required.	$50 copayment after deductible	Not Covered
Pediatric Vision Care - up to age 19 end of month		
Contact Lens 1 set of prescribed lenses and frames per 12-month period.	20% coinsurance not subject to deductible	Not Covered
Prescription Eye Glasses 1 set of prescribed lenses and frames per 12-month period.	20% coinsurance not subject to deductible	Not Covered
Routine Eye Exam 1 exam per 12-month period.	No Charge	Not Covered
Additional Covered Services		
Allergy Testing	Performed in a PCP Office: $25 copayment after deductible Performed in a Specialist Office: $50 copayment after deductible	50% coinsurance after deductible
Gym Reimbursement Gym reimbursement benefit does not apply towards the deductible or out-of-pocket maximum	$200 per 6-month calendar year period; $100 per 6-month calendar year period for covered Dependent(s)	$200 per 6-month calendar year period; $100 per 6-month calendar year period for covered Dependent(s)
Important information		

EmblemHealth plans are underwritten by Health Insurance Plan of Greater New York (HIP). The above benefits and services do not require referrals by a Select Care Network primary care physician.

Preauthorization will still be required for noted benefits. If you do not get Preauthorization for Out-of-Network services subject to this requirement, we will reduce your benefit by $500 or 50%, whichever is less to you. Participating physicians and providers have contracted with EmblemHealth to provide care to our members; they are not employees, agents, servants or representatives of EmblemHealth. This summary is provided for information only; it does not contain complete details or limitations of the Plan which are available only in the Contract or Certificate of Coverage/Insurance, and it does not constitute an agreement.

Refer to policy form number 155-OA-NSSGGoldPremierSch (4/25), et al.

Certain services must be approved in advance by EmblemHealth.

Our out-of-network provider reimbursement rate is at 80% of the Fair Health.

EmblemHealth®

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **877-411-3625** (TTY: **711**) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **877-411-3625** (TTY: **711**) o hable con su proveedor.

中文 (Simplified Chinese) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 **877-411-3625**（文本电话：**711**）或咨询您的服务提供商。

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **877-411-3625** (TTY: **711**) или обратитесь к своему поставщику услуг.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan **877-411-3625** (TTY: **711**) oswa pale avèk founisè w la.

한국어 (Korean) 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **877-411-3625** (TTY: **711**) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Italiano (Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' **877-411-3625** (tty: **711**) o parla con il tuo fornitore.

(**Yiddish**) **יידיש** נאטיץ: אויב איר רעדט יידיש, שפראך הילף סערוויסעס זענען בארעכטיגט פאר דיר פריי. צונעמען אַידס און באַדינונגס פֿאַר פֿראַוויידינג אינפֿאָרמאַציע אין צוטריטלעך פֿאָרמאַטירונגען זענען אויך בנימצא פריי. רופן **877-411-3625** (TTY: **711**) אָדער רעדן מיט דיין טרעגער.

EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

বাংলা (Bengali) মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। **877-411-3625** (TTY: **711**) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

POLSKI (Polish) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **877-411-3625** (TTY: **711**) lub porozmawiaj ze swoim dostawcą.

العربية (Arabic)

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **877-411-3625** (**711**) أو تحدث إلى مقدم الخدمة.

Français (French) ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **877-411-3625** (TTY: **711**) ou parlez à votre fournisseur.

اردو (Urdu)

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (TTY: **711**) **877-411-3625** پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **877-411-3625** (TTY: **711**) o makipag-usap sa iyong provider.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το **877-411-3625** (TTY: **711**) ή απευθυνθείτε στον πάροχό σας.

SHQIP (Albanian) VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi **877-411-3625** (TTY: **711**) ose bisedoni me ofruesin tuaj të shërbimit.

NOTICE OF NONDISCRIMINATION POLICY

Discrimination is Against the Law

EmblemHealth complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. EmblemHealth does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

EmblemHealth:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters.
    - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters.
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services contact the Civil Rights Coordinator by calling Customer Service at **877-411-3625** (TTY: **711**).

If you believe that EmblemHealth has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator by writing to the EmblemHealth Grievance and Appeals Department, P.O. Box 2844, New York, NY 10116-2844; faxing them at **212-510-5320**; or calling Customer Service at **877-411-3625**. (Dial **711** for TTY services.) You can file a grievance in person, by mail, by fax, or through your secure member portal. 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 for Civil Rights electronically through the Office for 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**; **800-368-1019** (TTY: **800-537-7697**).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

This notice is available on EmblemHealth's website at **emblemhealth.com/legal/nondiscrimination**.