## SUMMARY OF BENEFITS

### EmblemHealth Gold Value

<table>
<thead>
<tr>
<th>COST-SHARING</th>
<th>COMMENTS / LIMITATIONS</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Applies to hospital, medical, dental, vision and pharmacy</td>
<td>$3,000 per plan year</td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td>$6,000 per plan year</td>
</tr>
<tr>
<td>Prescription Drug Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$3,000 per plan year</td>
<td>$6,000 per plan year</td>
</tr>
<tr>
<td>Office Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician Office Visit</td>
<td>3 visits covered in full, not subject to deductible</td>
<td>After 3 visits, $45 copayment not subject to deductible</td>
</tr>
<tr>
<td>Specialist Care Physician Office Visit</td>
<td>PCP referral required</td>
<td>$65 copayment not subject to deductible</td>
</tr>
<tr>
<td>Teledermatology</td>
<td>PCP referral required</td>
<td>$0 copayment not subject to deductible</td>
</tr>
</tbody>
</table>

### PREVENTIVE CARE SERVICES

- Well-Baby and Well-Child Care, including Immunizations*: Covered in full
- Adult Annual Physical Checkup and Adult Immunizations*: Covered in full
- Routine Gynecological Services/Well Woman Exams, Mammography Screenings*: Covered in full
- Vasectomy: See surgical services below
- All other preventive services*: Covered in full
  *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF or HRSA

### EMERGENCY CARE

- Emergency Room: Copayment waived if admitted to hospital: $0 copayment after deductible
- Urgent Care Center: $75 copayment not subject to deductible
- Ambulance: $0 copayment after deductible

### PROFESSIONAL SERVICES and OUTPATIENT CARE

- Acupuncture: 12 visits per plan year: $0 copayment not subject to deductible
- Advanced Imaging: Referral required: $0 copayment after deductible
- Allergy Care
  - Performed in PCP Office: PCP referral required: $0 copayment after deductible
  - Performed in Specialist Office: $0 copayment after deductible
- Ambulatory Surgical Facility: Preauthorization required: $0 copayment after deductible
- Anesthesia Services (all settings): Covered in full
- Cardiac and Pulmonary Rehabilitation: Preauthorization required: $0 copayment after deductible
- Chemotherapy (all settings): Referral required to see specialist: $0 copayment after deductible
- Chiropractic Services: $65 copayment not subject to deductible
- Diagnostic Testing
  - Performed in PCP Office: PCP referral required: $0 copayment after deductible
  - Performed in Specialist Office: $0 copayment after deductible
- Dialysis: Referral required to see specialist: $0 copayment after deductible
- Habilitation and Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)
  - Preauthorization Required. Combined 60 visits/condition/plan year: $0 copayment after deductible
  - Unrestricted visits/year: $0 copayment after deductible
- Home Health Care: Preauthorization required. 40 visits per plan year: $0 copayment after deductible

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

2019
## Laboratory Procedures
- Performed in PCP Office: $45 copayment not subject to deductible
- Performed in Specialist Office: $65 copayment not subject to deductible

## Maternity and Newborn Care
- Inpatient Hospital and Birthing Center
  - Prenatal Care: Preauthorization required for inpatient services
  - Postnatal Care: $0 copayment after deductible, Covered in full

## Preadmission Testing
- Preauthorization required: $0 copayment not subject to deductible

## Diagnostic Radiology Services
- Performed in PCP Office: Preauthorization required
  - $0 copayment after deductible
- Performed in Specialist Office: Preauthorization required
  - $0 copayment after deductible

## Second Opinions on the Diagnosis of Cancer, Surgery and Other
- Referral required: $0 copayment after deductible

## Surgical Services
- Surgical Services in In-Patient/Out-Patient Facility
  - PCP Office Surgery: Preauthorization required
  - Specialist Office Surgery: Preauthorization required

## ADDITIONAL SERVICES, EQUIPMENT and DEVICES
- Diabetic Equipment, Supplies and Insulin: Preauthorization required
  - $0 copayment after deductible, per 30 day supply
- Durable Medical Equipment: Preauthorization required. One external prosthetic device per limb per lifetime with coverage for repairs and replacement. No orthotics.
  - 0% coinsurance after deductible
- External Hearing Aids: Preauthorization required. Single purchase, once every three years.
  - 0% coinsurance after deductible
- Inpatient Hospice Care: Preauthorization required. 210 days per plan year
  - $0 copayment after deductible

## INPATIENT SERVICES and FACILITIES
- Inpatient Hospital Service: Preauthorization required, except for emergency admissions
  - $0 copayment after deductible per admission
- Skilled Nursing Facility Care: Preauthorization required. 200 days per plan year
  - $0 copayment after deductible per admission
- Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy): Preauthorization required. 60 days per plan year, combined therapies. Speech and physical therapy are only covered following a hospital stay or surgery
  - $0 copayment after deductible per admission
- Inpatient Habilitation Services (Physical, Speech and Occupational Therapy): Preauthorization required. 60 days per plan year, combined therapies
  - $0 copayment after deductible per admission

## MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES
- Inpatient Mental Health Care: Preauthorization required, except for emergency admissions
  - $0 copayment after deductible per admission
- Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services): $45 copayment not subject to deductible
- Inpatient Substance Use Services: Preauthorization required, except for Emergency Admissions or for Participating OASAS-certified Facilities
  - $0 copayment after deductible per admission
- Outpatient Substance Use Services: Up to 20 visits per plan year may be used for family counseling.
  - $45 copayment not subject to deductible

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2019
## Prescription Drugs

<table>
<thead>
<tr>
<th>Pharmacy Type</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Preauthorization</th>
<th>$25 copayment not subject to deductible</th>
<th>$0 copayment after deductible</th>
<th>$0 copayment after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mail Order Pharmacy</td>
<td>$63 copayment not subject to deductible</td>
<td>$0 copayment after deductible</td>
<td>$0 copayment after deductible</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Wellness Benefits

<table>
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<tr>
<th>Benefit</th>
<th>Comments/Limitations</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gym Reimbursement</td>
<td>Gym reimbursement benefit does not apply towards the deductible or out of pocket maximum</td>
<td>Subscriber reimbursed up to $200 for completion of 50 exercise facility visits in each six month period. Covered spouse reimbursed up to $100 per six-month period and 50 visits.</td>
</tr>
</tbody>
</table>

## Pediatric Vision Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage</th>
<th>$0 copayment not subject to deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams</td>
<td>One exam per 12 month period, coverage up to age 19 end of month.</td>
<td></td>
</tr>
<tr>
<td>Lenses and Frames</td>
<td>One set of lenses and frames or contacts per 12 month period, coverage up to age 19 end of month.</td>
<td>20% coinsurance not subject to deductible</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td></td>
<td>20% coinsurance not subject to deductible</td>
</tr>
</tbody>
</table>

## Adult Vision Care

<table>
<thead>
<tr>
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## Pediatric Dental Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cover</th>
<th>$45 copayment not subject to deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Dental Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Dental Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Dental Care</td>
<td>Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 month intervals.</td>
<td>$45 copayment not subject to deductible</td>
</tr>
<tr>
<td>Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery)</td>
<td>Requires preauthorization</td>
<td>$65 copayment not subject to deductible</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>Requires preauthorization</td>
<td>$65 copayment not subject to deductible</td>
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## Adult Dental Care

<table>
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<tr>
<th>Benefit</th>
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<tbody>
<tr>
<td>Emergency Dental Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Dental Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Dental Care</td>
<td>Full mouth x-rays or panoramic x-rays at thirty-six 36 month intervals and bitewing x-rays at 6 month intervals.</td>
<td>$45 copayment not subject to deductible</td>
</tr>
</tbody>
</table>

EmblemHealth Plans are underwritten by Health Insurance Plan of Greater New York. Except for emergency care, the above benefits and services are covered only when provided or referred by a Select Care network primary care physician and/or approved in advance by the EmblemHealth Care Management Program. 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 HIP policy form number 155-23-NISON/HIXOC68046 (04/19), et al. Certain services must be approved in advance by EmblemHealth. Second-opinions on diagnosis of cancer are covered at participating cost-sharing for non-participating Specialist when a referral is obtained. Dialysis performed by non-participating providers is limited to 10 visits per calendar year. Preauthorization required.
ATTENTION: Language assistance services, free of charge, are available to you. Call 1-877-411-3625 (TTY/TDD: 711).

Español (Spanish)

中文 (Traditional Chinese)
注意：我們免費提供相關的語言協助服務。請致電 1-877-411-3625 (TTY/TDD: 711)。

Русский (Russian)

Kreyòl Ayisyen (Haitian Creole)

한국어 (Korean)

Italiano (Italian)

אידיש (Yiddish)

বাংলা (Bengali)
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Polski (Polish)

العربية (Arabic)
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Français (French)
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**EmblemHealth:**
- Provides free aids and services to people with disabilities to help
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call member services at 1-877-411-3625 (TTY/TDD: 711).

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Complaint forms are available at [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html).