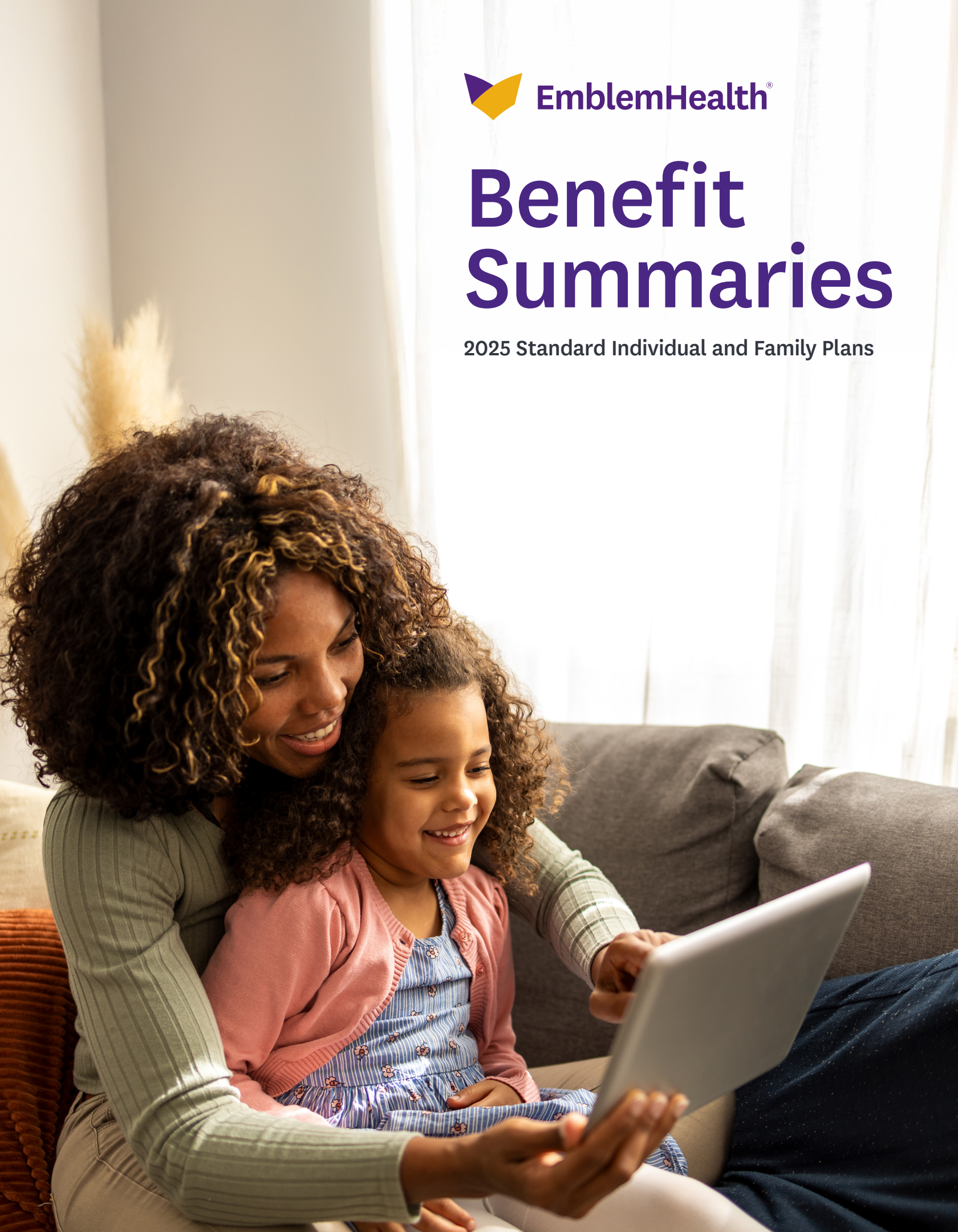
EmblemHealth®

Benefit Summaries

2025 Standard Individual and Family Plans



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EmblemHealth Individual and Family Plans

For more than 85 years, EmblemHealth companies have offered quality, affordable health insurance to the New York community.

This brochure shares the Benefit Summaries for our standard individual and family plans. Our plans are designed to meet your health insurance needs and budget.

How Do I Enroll?

Joining an EmblemHealth plan is easy.

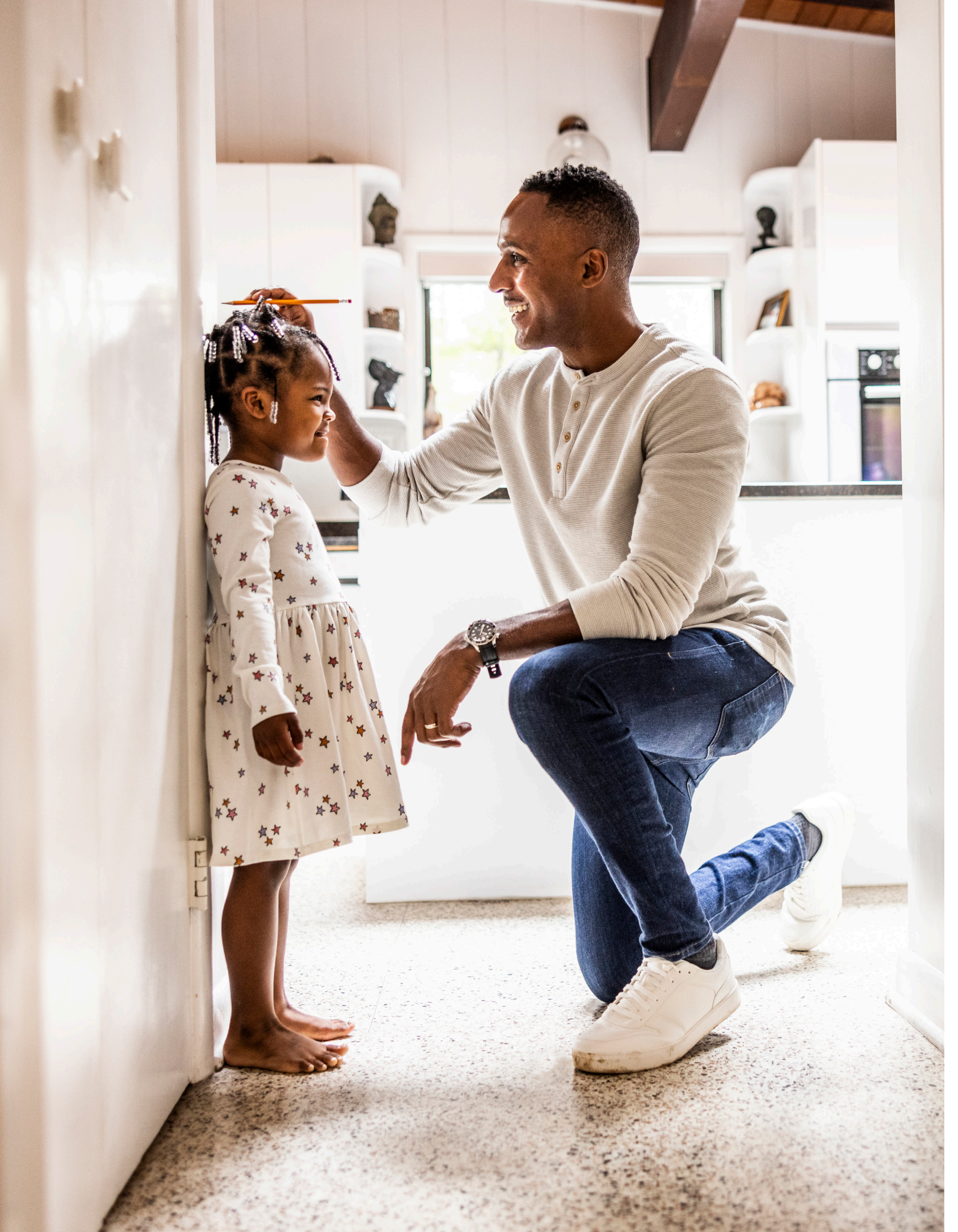
For plans through NY State of Health, go to **nystateofhealth.ny.gov**. We encourage you to find out if you qualify for financial help paying your monthly premium, available through the NY State of Health. If you do, you must enroll in a plan through the NY State of Health.

If you don't qualify, you can enroll in a plan directly through EmblemHealth.

Before applying, gather these items for each member of your household who needs health care coverage:

- **Social Security numbers** (or immigration documentation for legally residing immigrants).
- **Employer and income information** (for example, from your pay stubs or W-2 — Wage and Tax Statements).
- **Policy numbers** for any current health insurance plans covering members of your household.
- **Permanent address** (required to establish an account).
- **Email address** (strongly encouraged to maintain communication about your plan).

Or, visit **emblemhealth.com/individualsandfamilies** to enroll. If you have any questions about these plans, you can reach us at **866-838-9144** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week.



EmblemHealth Standard Plans

You can purchase these plans through NY State of Health or directly through EmblemHealth:	
EmblemHealth Select Care Platinum/ EmblemHealth Select Care Platinum D	EmblemHealth Millennium Platinum/ EmblemHealth Millennium Platinum D
EmblemHealth Select Care Gold/ EmblemHealth Select Care Gold D	EmblemHealth Millennium Gold/ EmblemHealth Millennium Gold D
EmblemHealth Select Care Silver/ EmblemHealth Select Care Silver D	EmblemHealth Millennium Silver/ EmblemHealth Millennium Silver D
EmblemHealth Select Care Bronze/ EmblemHealth Select Care Bronze D	EmblemHealth Millennium Bronze/ EmblemHealth Millennium Bronze D
EmblemHealth Select Care Catastrophic/ EmblemHealth Select Care Catastrophic D	EmblemHealth Millennium Catastrophic/ EmblemHealth Millennium Catastrophic D

All of these plans are health maintenance organization (HMO) plans. With HMO plans, you choose a primary care provider (PCP) who will provide your everyday care. These plans offer pediatric dental benefits for children up to age 19.

Help Paying Your Premium

Tax credits are provided by the U.S. government to those who qualify to help people pay their monthly costs of a health plan. If you qualify for a tax credit, you must enroll in a plan through the NY State of Health. To learn more about financial assistance, visit **emblemhealth.com/plans/individuals-and-families/financial-help**.

EmblemHealth Individual and Family plans use the Millennium Network or the Select Care Network depending on where the plan subscriber lives.

Service Area

To enroll in an EmblemHealth Millennium plan, you must live in New York City (Brooklyn, the Bronx, Manhattan, Queens, or Staten Island), Long Island (Nassau or Suffolk counties), Rockland, or Westchester county.

To enroll in an EmblemHealth Select Care plan, you must live in Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Orange, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, or Washington counties.

IMPORTANT THINGS YOU NEED TO KNOW ABOUT THESE PLANS

Here are a few important things you need to know about these plans:

- You need to select a primary care provider (PCP) who participates in your plan's network.
- You have in-network coverage only, except hospital care for an emergency condition is covered in- or out-of-network.
- You'll need a referral (or approval) from your PCP to see specialists when needed. Specialists are doctors who provide services other than primary care, such as allergists, dermatologists, cardiologists, etc.
- You do not need an approval for all services. For example, you don't need approval from your PCP for:
  - Chiropractic services.
  - Outpatient mental health services and substance use disorder treatment services.
  - Primary gynecologic and obstetric care.
  - Refractive eye exams from an optometrist for covered children. (This is only covered up to the end of the month in which the child turns age 19.)
  - Diabetic eye exams from an ophthalmologist.
  - Dental and vision services.
- Preventive care is usually covered in full and not subject to deductible as long as you use an in-network health care professional. These services include routine physicals, screenings, immunizations, mammograms, gynecological exams, well-baby care, and prescription contraceptives for women. Treatments are covered in full for members diagnosed with diabetes.
- Prescription drug coverage is included in these plans. All prescription drug benefits must be obtained through pharmacies that contract with your plan. The pharmacist will apply any plan deductibles or copays when you pay for your prescription.

Glossary

A **premium** is the amount you pay for your insurance every month.

A **deductible** is the amount you pay each year before your plan starts to pay benefits.

A **copayment** (also called a copay) is the set amount you pay for covered health services, like seeing a doctor or paying for a drug at the pharmacy.

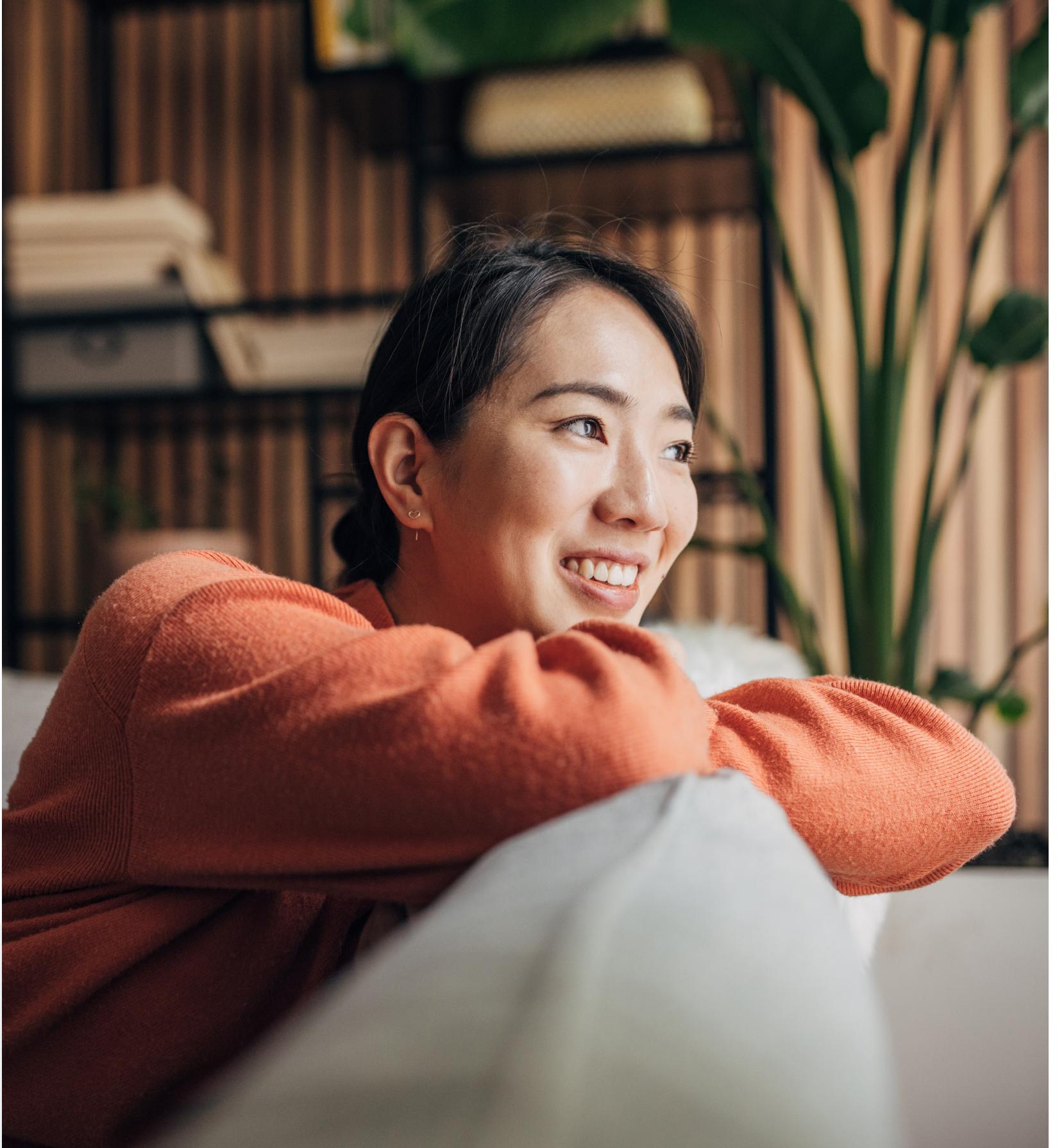
Coinsurance is the percentage you pay for health services, usually after you pay your deductible.

A **network** is a group of health care professionals or facilities that have contracted with a health plan. They provide covered products and services to members.

Out-of-pocket costs are what you pay for health services. These include deductibles, coinsurance, and copayments.

A **referral** is permission or approval from your doctor to see a specialist.

Tax credits are a form of financial assistance from the U.S. government to help people pay for the monthly costs of their health plan (the premium).



EmblemHealth Standard Plans

EmblemHealth Millennium Platinum/EmblemHealth Select Care Platinum

This is an HMO plan with no annual deductible and low out-of-pocket costs. All of EmblemHealth's individual and family plans cover the same health benefits, but at different monthly premiums and out-of-pocket costs.

Benefit Summary	
Major Cost-Sharing Provisions	**Copay/Limitations**
Primary care provider (PCP) office visits	$15 copay per visit
Specialist office visits	$35 copay per visit
Telemedicine*	Covered in full
Hospital admission	$500 copay per hospital admission
Emergency room copay (waived if admitted)	$100 copay per visit
Annual deductible (individual/family)	$0/$0
Annual out-of-pocket maximum (individual/family)	$2,000/$4,000
Prescription drugs	$10 copay generic, $30 copay preferred brand, $60 copay non-preferred brand
Inpatient Hospital Services	**Copay/Limitations**
Inpatient physician and surgical services	$100 copay
Semi-private room and board	Included in hospital admission copay
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, x-rays, and lab tests	Included in hospital admission copay
Short-term speech, physical, occupational, and respiratory therapy (when part of an acute admission)	Included in hospital admission copay
Speech, physical, occupational, and respiratory therapy (when part of a rehabilitation admission)	Included in hospital admission copay
Radiation therapy and chemotherapy	Subject to PCP office visit copay
Pre-admission testing	Covered in full
Outpatient Medical Care	**Copay/Limitations**
PCP office visits	Subject to PCP office visit copay
Specialist office visits	Subject to specialist office visit copay
Preventive care** including physical exams, ear exams, health education and counseling, pap smear, mammography, and immunizations	Covered in full
Well-child care**	Covered in full
Diagnostic laboratory services	Performed in a PCP office: $15 copay Performed in a specialist office: $35 copay
Prenatal care in physician's office	Covered in full
Ambulatory surgery	$100 copay
Second medical and surgical opinion	Subject to specialist office visit copay
Chiropractic services	Subject to specialist office visit copay
Mental Health and Substance Use Disorder	**Copay/Limitations**
Mental health care	
Inpatient treatment of mental illness	Subject to hospital admission copay; no limit on days per calendar year
Outpatient treatment of mental illness	Subject to PCP office visit copay; no limit on days per calendar year
Substance use disorder	
Inpatient detoxification	Subject to hospital admission copay; no limit on days per calendar year
Inpatient rehabilitation treatment	Subject to hospital admission copay; no limit on days per calendar year
Outpatient rehabilitation treatment	Subject to PCP office visit copay; no limit on days per calendar year

Benefit Summary	
Special Kinds of Care	**Copay/Limitations**
In hospital emergency room	$100 copay per visit (waived if admitted)
In urgent care facility	$55 copay
Ambulance service to the hospital	$100 copay
Home health care	Subject to PCP office visit copay
Outpatient hospice care	Subject to PCP office visit copay
Skilled nursing facility care	Subject to hospital admission copay
Dialysis treatment	Subject to PCP office visit copay
Diabetes equipment, supplies, and education	Subject to PCP office visit copay
Outpatient physical, speech, occupational, and respiratory therapy	$25 copay
Family planning services	Covered in full
Durable medical equipment	10% coinsurance
Hearing aids	10% coinsurance
Pediatric Dental Benefits	**Copay/Limitations**
Emergency dental care	$15 copay
Preventive dental care (dental exam and cleaning)	$15 copay/1 every 6 months
Routine dental care	$15 copay
Major dental care	$15 copay
Orthodontics	$15 copay
Pediatric Vision Care Benefits	**Copay/Limitations**
Exams	$15 copay/1 every 12 months
Lenses and frames	10% coinsurance/1 every 12 months
Contact lenses	10% coinsurance/1 every 12 months

EmblemHealth Qualified Health Plans are underwritten by Health Insurance Plan of Greater New York (HIP). Except for emergency care, the above benefits and services are covered only when provided or referred by a Millennium or Select Care (as applicable to your plan) Network primary care provider and/or approved in advance by the EmblemHealth Utilization 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 of the plan, which are available only in the Contract or Certificate of Coverage, and it does not constitute an agreement. Refer to HIP policy form numbers 155-23-IONHIXHMO (4/24), 155-23-IOFFHIXCONT (4/24), et al.

* Telemedicine benefit is provided through Teladoc®. It is not appropriate for all covered services, restrictions apply, and not all services are available 24/7.

** Preventive care and well-child care services are covered in full in-network when given an A or B rating by the United States Preventive Services Task Force (USPSTF), recommended by the Advisory Committee on Immunization Practices (ACIP), provided in accordance with Health Resources and Services Administration (HRSA) guidelines or when required by New York state law.

Certain services may require preauthorization.

EmblemHealth Millennium Gold/EmblemHealth Select Care Gold

This HMO plan has the second-lowest cost-sharing of the EmblemHealth metal plans. All of EmblemHealth's individual and family plans cover the same health benefits, but at different monthly premiums and out-of-pocket costs.

Benefit Summary	
Major Cost-Sharing Provisions	**Copay/Limitations**
Primary care provider (PCP) office visits	$25 copay per visit after deductible
Specialist office visits	$40 copay per visit after deductible
Telemedicine*	Covered in full
Hospital admission	$1,000 copay per visit after deductible
Emergency room copay (waived if admitted)	$150 copay per visit after deductible
Annual deductible (individual/family)	$600/$1,200
Annual out-of-pocket maximum (individual/family)	$7,900/$15,800
Prescription drugs	$10 copay generic, $35 copay preferred brand, $70 copay non-preferred brand
Inpatient Hospital Services	**Copay/Limitations**
Inpatient physician and surgical services	$100 copay after deductible
Semi-private room and board	Included in hospital admission copay after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, x-rays, and lab tests	Included in hospital admission copay after deductible
Short-term speech, physical, occupational, and respiratory therapy (when part of an acute admission)	Included in hospital admission copay after deductible; short-term only
Speech, physical, occupational, and respiratory therapy (when part of a rehabilitation admission)	Included in hospital admission copay after deductible
Radiation therapy and chemotherapy	Subject to PCP office visit copay after deductible
Pre-admission testing	$0 copay after deductible
Outpatient Medical Care	**Copay/Limitations**
PCP office visits	Subject to PCP office visit copay after deductible
Specialist office visits	Subject to specialist office visit copay after deductible
Preventive care** including physical exams, ear exams, health education and counseling, pap smear, mammography, and immunizations	Covered in full
Well-child care**	Covered in full
Diagnostic laboratory services	Performed in a PCP office: $25 copay Performed in a specialist office: $40 copay after deductible
Prenatal care in physician's office	Covered in full
Ambulatory surgery	$100 copay after deductible
Second medical and surgical opinion	Subject to specialist office visit copay after deductible
Chiropractic services	Subject to specialist office visit copay after deductible
Mental Health and Substance Use Disorder	**Copay/Limitations**
Mental health care	
Inpatient treatment of mental illness	Subject to hospital admission copay after deductible; no limit on days per calendar year
Outpatient treatment of mental illness	Subject to PCP office visit copay after deductible; no limit on visits per calendar year
Substance use disorder	
Inpatient detoxification	Subject to hospital admission copay after deductible; no limit on days per calendar year
Inpatient rehabilitation treatment	Subject to hospital admission copay after deductible; no limit on days per calendar year
Outpatient rehabilitation treatment	Subject to PCP office visit copay after deductible; no limit on visits per calendar year

Benefit Summary	
Special Kinds of Care	**Copay/Limitations**
In hospital emergency room	$150 copay per visit after deductible (waived if admitted)
In urgent care facility	$60 copay after deductible
Ambulance service to the hospital	$150 copay after deductible
Home health care	Subject to PCP office visit copay after deductible
Outpatient hospice care	Subject to PCP office visit copay after deductible
Skilled nursing facility care	Subject to hospital admission copay after deductible
Dialysis treatment	Subject to PCP office visit copay after deductible
Diabetes equipment, supplies, and education	Subject to PCP office visit copay after deductible
Outpatient physical, speech, occupational, and respiratory therapy	$30 copay after deductible
Family planning services	Covered in full
Durable medical equipment	20% coinsurance after deductible
Hearing aids	20% coinsurance after deductible
Pediatric Dental Benefits	**Copay/Limitations**
Emergency dental care	$25 copay after deductible
Preventive dental care (dental exam and cleaning)	$25 copay after deductible/1 every 6 months
Routine dental care	$25 copay after deductible
Major dental care	$25 copay after deductible
Orthodontics	$25 copay after deductible
Pediatric Vision Care Benefits	**Copay/Limitations**
Exams	$25 copay after deductible/1 every 12 months
Lenses and frames	20% coinsurance after deductible/1 every 12 months
Contact lenses	20% coinsurance after deductible/1 every 12 months

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Certain services may require preauthorization.

EmblemHealth Millennium Silver/EmblemHealth Select Care Silver

The Silver HMO plan offers individuals lower monthly premiums and higher out-of-pocket costs. Just like the other metal plans available at NY State of Health, people may be eligible for tax credits. It is the most popular of the standard metal plans.

Benefit Summary	
Major Cost-Sharing Provisions	**Copay/Limitations**
Primary care provider (PCP) office visits	1 visit (any combination of PCP, specialist, applied behavioral analysis, mental health/substance use disorder) for $30 copay per visit before deductible; thereafter, $30 copay per visit after deductible
Specialist office visits	1 visit (any combination of PCP, specialist, applied behavioral analysis, mental health/substance use disorder) for $65 copay per visit before deductible; thereafter, $65 copay per visit after deductible
Telemedicine*	Covered in full
Hospital admission	$1,500 copay per hospital admission after deductible
Emergency room copay (waived if admitted)	$500 copay per visit after deductible
Annual deductible (individual/family)	$2,100/$4,200
Annual out-of-pocket maximum (individual/family)	$9,200/$18,400
Prescription drugs	$15 copay generic, $40 copay preferred brand, $75 copay non-preferred brand
Inpatient Hospital Services	**Copay/Limitations**
Inpatient physician and surgical services	$150 copay after deductible
Semi-private room and board	Included in hospital admission copay after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, x-rays, and lab tests	Included in hospital admission copay after deductible
Short-term speech, physical, occupational, and respiratory therapy (when part of an acute admission)	Included in hospital admission copay after deductible; short-term only
Speech, physical, occupational, and respiratory therapy (when part of a rehabilitation admission)	Included in hospital admission copay after deductible
Radiation therapy and chemotherapy	Subject to PCP office visit copay after deductible
Pre-admission testing	$0 copay after deductible
Outpatient Medical Care	**Copay/Limitations**
PCP office visits	Subject to PCP office visit copay after deductible
Specialist office visits	Subject to specialist office visit copay after deductible
Preventive care** including physical exams, ear exams, health education and counseling, pap smear, mammography, and immunizations	Covered in full
Well-child care**	Covered in full
Diagnostic laboratory services	Performed in a PCP office: $30 copay Performed in a specialist office: $50 copay after deductible
Prenatal care in physician's office	Covered in full
Ambulatory surgery	$150 copay after deductible
Second medical and surgical opinion	Subject to specialist office visit copay after deductible
Chiropractic services	Subject to specialist office visit copay after deductible
Mental Health and Substance Use Disorder	**Copay/Limitations**
Mental health care	
Inpatient treatment of mental illness	Subject to hospital admission copay after deductible; no limit on days per calendar year
Outpatient treatment of mental illness	Subject to PCP office visit copay after deductible; no limit on visits per calendar year
Substance use disorder	
Inpatient detoxification	Subject to hospital admission copay after deductible; no limit on days per calendar year
Inpatient rehabilitation treatment	Subject to hospital admission copay after deductible; no limit on days per calendar year
Outpatient rehabilitation treatment	Subject to PCP office visit copay after deductible; no limit on visits per calendar year

Benefit Summary	
Special Kinds of Care	**Copay/Limitations**
In hospital emergency room	$500 copay per visit after deductible (waived if admitted)
In urgent care facility	$70 copay after deductible
Ambulance service to the hospital	$150 copay after deductible
Home health care	$30 copay after deductible
Outpatient hospice care	$30 copay after deductible
Skilled nursing facility care	Subject to hospital admission copay after deductible
Dialysis treatment	$30 copay after deductible
Diabetes equipment, supplies, and education	$30 copay after deductible
Outpatient physical, speech, occupational, and respiratory therapy	$30 copay after deductible
Family planning services	Covered in full
Durable medical equipment	30% coinsurance after deductible
Hearing aids	30% coinsurance after deductible
Pediatric Dental Benefits	**Copay/Limitations**
Emergency dental care	$30 copay after deductible
Preventive dental care (dental exam and cleaning)	$30 copay after deductible/1 every 6 months
Routine dental care	$30 copay after deductible
Major dental care	$30 copay after deductible
Orthodontics	$30 copay after deductible
Pediatric Vision Care Benefits	**Copay/Limitations**
Exams	$30 copay after deductible/1 every 12 months
Lenses and frames	30% coinsurance after deductible/1 every 12 months
Contact lenses	30% coinsurance after deductible/1 every 12 months

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* Telemedicine benefit is provided through Teladoc®. It is not appropriate for all covered services, restrictions apply, and not all services are available 24/7.

** Preventive care and well-child care services are covered in full in-network when given an A or B rating by the United States Preventive Services Task Force (USPSTF), recommended by the Advisory Committee on Immunization Practices (ACIP), provided in accordance with Health Resources and Services Administration (HRSA) guidelines or when required by New York state law.

Certain services may require preauthorization.

EmblemHealth Millennium Bronze/EmblemHealth Select Care Bronze

The Bronze HMO plan includes three annual visits to your primary care provider before your deductible. All of EmblemHealth's individual and family plans cover the same benefits, but at different monthly premiums and out-of-pocket costs.

Benefit Summary	
Major Cost-Sharing Provisions	**Copay/Limitations**
Primary care provider (PCP) office visits	3 visits (any combination of PCP, specialist, applied behavioral analysis, mental health/substance use disorder) for $50 copay per visit before deductible; thereafter, $50 after deductible
Specialist office visits	3 visits (any combination of PCP, specialist, applied behavioral analysis, mental health/substance use disorder) for $75 copay per visit before deductible; thereafter, $75 after deductible
Telemedicine*	Covered in full
Hospital admission	$1,500 copay after deductible
Emergency room copay (waived if admitted)	$500 copay after deductible
Annual deductible (individual/family)	$3,800/$7,600
Annual out-of-pocket maximum (individual/family)	$9,200/$18,400
Prescription drugs	$10 copay generic, $35 copay preferred brand, $70 copay non-preferred brand after deductible
Inpatient Hospital Services	**Copay/Limitations**
Inpatient physician and surgical services	$150 copay after deductible
Semi-private room and board	Included in hospital admission copay after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, x-rays, and lab tests	Included in hospital admission copay after deductible
Short-term speech, physical, occupational, and respiratory therapy (when part of an acute admission)	Included in hospital admission copay after deductible; short-term only
Speech, physical, occupational, and respiratory therapy (when part of a rehabilitation admission)	Included in hospital admission copay after deductible
Radiation therapy and chemotherapy	Subject to PCP office visit copay after deductible
Pre-admission testing	$0 copay after deductible
Outpatient Medical Care	**Copay/Limitations**
PCP office visits	Subject to PCP office visit copay after deductible
Specialist office visits	Subject to specialist office visit copay after deductible
Preventive care** including physical exams, ear exams, health education and counseling, pap smear, mammography, and immunizations	Covered in full
Well-child care**	Covered in full
Diagnostic laboratory services	$50 copay after deductible
Prenatal care in physician's office	Covered in full
Ambulatory surgery	$150 copay after deductible
Second medical and surgical opinion	Subject to specialist office visit copay after deductible
Chiropractic services	Subject to specialist office visit copay after deductible
Mental Health and Substance Use Disorder	**Copay/Limitations**
Mental health care	
Inpatient treatment of mental illness	Subject to hospital admission copay after deductible; no limit on days per calendar year
Outpatient treatment of mental illness	Subject to PCP office visit copay after deductible; no limit on visits per calendar year
Substance use disorder	
Inpatient detoxification	Subject to hospital admission copay after deductible; no limit on days per calendar year
Inpatient rehabilitation treatment	Subject to hospital admission copay after deductible; no limit on days per calendar year
Outpatient rehabilitation treatment	Subject to PCP office visit copay after deductible; no limit on visits per calendar year

Benefit Summary	
Special Kinds of Care	**Copay/Limitations**
In hospital emergency room	$500 copay per visit after deductible (waived if admitted)
In urgent care facility	$75 after deductible
Ambulance service to the hospital	$300 copay after deductible
Home health care	$50 copay after deductible
Outpatient hospice care	$50 copay after deductible
Skilled nursing facility care	Subject to hospital admission copay after deductible
Dialysis treatment	$50 copay after deductible
Diabetes equipment, supplies, and education	$50 copay after deductible
Outpatient physical, speech, occupational, and respiratory therapy	$50 copay after deductible
Family planning services	Covered in full
Durable medical equipment	50% coinsurance after deductible
Hearing aids	50% coinsurance after deductible
Pediatric Dental Benefits	**Copay/Limitations**
Emergency dental care	$50 copay after deductible
Preventive dental care (dental exam and cleaning)	$50 copay after deductible/1 every 6 months
Routine dental care	$50 copay after deductible
Major dental care	$50 copay after deductible
Orthodontics	$50 copay after deductible
Pediatric Vision Care Benefits	**Copay/Limitations**
Exams	$50 copay after deductible/1 every 12 months
Lenses and frames	50% coinsurance after deductible/1 every 12 months
Contact lenses	50% coinsurance after deductible/1 every 12 months

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Certain services may require preauthorization.

EmblemHealth Millennium Catastrophic/EmblemHealth Select Care Catastrophic

This is an HMO plan for individuals under age 30 and others who qualify based on financial need. It includes three annual visits to a primary care provider before your deductible. All of EmblemHealth's individual and family plans cover the same health benefits, but at different monthly premiums and out-of-pocket costs.

Benefit Summary	
Major Cost-Sharing Provisions	**Copay/Limitations**
Primary care provider (PCP) office visits	3 $0 copay PCP visits (any combination of PCP, mental health/substance use disorder), then 0% coinsurance after deductible
Specialist office visits	0% coinsurance after deductible
Telemedicine*	Covered in full after deductible
Hospital admission	0% coinsurance after deductible
Emergency room copay (waived if admitted)	0% coinsurance after deductible
Annual deductible (individual/family)	$9,200/$18,400
Annual out-of-pocket maximum (individual/family)	$9,200/$18,400
Prescription drugs	0% coinsurance after deductible
Inpatient Hospital Services	**Copay/Limitations**
Inpatient physician and surgical services	0% coinsurance after deductible
Semi-private room and board	0% coinsurance after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, x-rays, and lab tests	0% coinsurance after deductible
Short-term speech, physical, occupational, and respiratory therapy (when part of an acute admission)	0% coinsurance after deductible
Speech, physical, occupational, and respiratory therapy (when part of a rehabilitation admission)	0% coinsurance after deductible
Radiation therapy and chemotherapy	0% coinsurance after deductible
Pre-admission testing	0% coinsurance after deductible
Outpatient Medical Care	**Copay/Limitations**
PCP office visits	0% coinsurance after deductible
Specialist office visits	0% coinsurance after deductible
Preventive care** including physical exams, ear exams, health education and counseling, pap smear, mammography, and immunizations	Covered in full
Well-child care**	Covered in full
Diagnostic laboratory services	0% coinsurance after deductible
Prenatal care in physician's office	Covered in full
Ambulatory surgery	0% coinsurance after deductible
Second medical and surgical opinion	0% coinsurance after deductible
Chiropractic services	0% coinsurance after deductible
Mental Health and Substance Use Disorder	**Copay/Limitations**
Mental health care	
Inpatient treatment of mental illness	0% coinsurance after deductible
Outpatient treatment of mental illness	0% coinsurance after deductible
Substance use disorder	
Inpatient detoxification	0% coinsurance after deductible
Inpatient rehabilitation treatment	0% coinsurance after deductible
Outpatient rehabilitation treatment	0% coinsurance after deductible

Benefit Summary	
Special Kinds of Care	**Copay/Limitations**
In hospital emergency room	0% coinsurance after deductible
In urgent care facility	0% coinsurance after deductible
Ambulance service to the hospital	0% coinsurance after deductible
Home health care	0% coinsurance after deductible
Outpatient hospice care	0% coinsurance after deductible
Skilled nursing facility care	0% coinsurance after deductible
Dialysis treatment	0% coinsurance after deductible
Diabetes equipment, supplies, and education	0% coinsurance after deductible
Outpatient physical, speech, occupational, and respiratory therapy	0% coinsurance after deductible
Family planning services	Covered in full
Durable medical equipment	0% coinsurance after deductible
Hearing aids	0% coinsurance after deductible
Pediatric Dental Benefits	**Copay/Limitations**
Emergency dental care	0% coinsurance after deductible
Preventive dental care (dental exam and cleaning)	0% coinsurance after deductible/1 every 6 months
Routine dental care	0% coinsurance after deductible
Major dental care	0% coinsurance after deductible
Orthodontics	0% coinsurance after deductible
Pediatric Vision Care Benefits	**Copay/Limitations**
Exams	0% coinsurance after deductible/1 every 12 months
Lenses and frames	0% coinsurance after deductible/1 every 12 months
Contact lenses	0% coinsurance after deductible/1 every 12 months

EmblemHealth Qualified Health Plans are underwritten by Health Insurance Plan of Greater New York (HIP). Except for emergency care, the above benefits and services are covered only when provided or referred by a Millennium or Select Care (as applicable to your plan) Network primary care provider and/or approved in advance by the EmblemHealth Utilization 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 of the plan, which are available only in the Contract or Certificate of Coverage, and it does not constitute an agreement. Refer to HIP policy form numbers 155-23-IONHIXHMO (4/24), 155-23-IOFFHIXCONT (4/24), et al.

* Telemedicine benefit is provided through Teladoc®. It is not appropriate for all covered services, restrictions apply, and not all services are available 24/7.

** Preventive care and well-child care services are covered in full in-network when given an A or B rating by the United States Preventive Services Task Force (USPSTF), recommended by the Advisory Committee on Immunization Practices (ACIP), provided in accordance with Health Resources and Services Administration (HRSA) guidelines or when required by New York state law.

Certain services may require preauthorization.

EmblemHealth Direct Pay Rates

Millennium Plan Rates

Listed below are the monthly premium rates for EmblemHealth plans by region.

Rates are effective Jan. 1, 2025 through Dec. 31, 2025.

		EmblemHealth Platinum	EmblemHealth Gold	EmblemHealth Silver	EmblemHealth Bronze	EmblemHealth Catastrophic
Downstate	Individual	$2,344.44	$1,936.65	$1,606.81	$1,225.28	$798.43
	Individual & Spouse	$4,688.88	$3,873.30	$3,213.62	$2,450.56	$1,596.86
	Parent & Child(ren)	$3,985.55	$3,292.31	$2,731.58	$2,082.98	$1,357.33
	Family	$6,681.65	$5,519.45	$4,579.41	$3,492.05	$2,275.53
	Child Only	$965.91	$797.90	$662.01	$504.82	N/A
Long Island	Individual	$2,533.57	$2,092.89	$1,736.44	$1,324.13	$862.84
	Individual & Spouse	$5,067.14	$4,185.78	$3,472.88	$2,648.26	$1,725.68
	Parent & Child(ren)	$4,307.07	$3,557.91	$2,951.95	$2,251.02	$1,466.83
	Family	$7,220.67	$5,964.74	$4,948.85	$3,773.77	$2,459.09
	Child Only	$1,043.83	$862.27	$715.41	$545.54	N/A

Listed below are the monthly premium rates **with age 29 rider**, which extends coverage for adult children through age 29 (up to 30th birthday).

		EmblemHealth Platinum Age 29	EmblemHealth Gold Age 29	EmblemHealth Silver Age 29	EmblemHealth Bronze Age 29
Downstate	Individual	$2,414.77	$1,994.75	$1,655.01	$1,262.04
	Individual & Spouse	$4,829.54	$3,989.50	$3,310.02	$2,524.08
	Parent & Child(ren)	$4,105.11	$3,391.08	$2,813.52	$2,145.47
	Family	$6,882.09	$5,685.04	$4,716.78	$3,596.81
Long Island	Individual	$2,609.58	$2,155.68	$1,788.53	$1,363.85
	Individual & Spouse	$5,219.16	$4,311.36	$3,577.06	$2,727.70
	Parent & Child(ren)	$4,436.29	$3,664.66	$3,040.50	$2,318.55
	Family	$7,437.30	$6,143.69	$5,097.31	$3,886.97

Downstate: Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester

Long Island: Nassau, Suffolk

Select Care Plan Rates

Listed below are the monthly premium rates for EmblemHealth plans by region.

Rates are effective Jan. 1, 2025 through Dec. 31, 2025.

		EmblemHealth Platinum	EmblemHealth Gold	EmblemHealth Silver	EmblemHealth Bronze	EmblemHealth Catastrophic
Albany	Individual	$2,893.01	$2,389.79	$1,982.78	$1,511.95	$985.21
	Individual & Spouse	$5,786.02	$4,779.58	$3,965.56	$3,023.90	$1,970.42
	Parent & Child(ren)	$4,918.12	$4,062.64	$3,370.73	$2,570.32	$1,674.86
	Family	$8,245.08	$6,810.90	$5,650.92	$4,309.06	$2,807.85
	Child Only	$1,191.92	$984.59	$816.91	$622.92	N/A
Mid-Hudson	Individual	$2,894.24	$2,390.81	$1,983.62	$1,512.59	$985.63
	Individual & Spouse	$5,788.48	$4,781.62	$3,967.24	$3,025.18	$1,971.26
	Parent & Child(ren)	$4,920.21	$4,064.38	$3,372.15	$2,571.40	$1,675.57
	Family	$8,248.58	$6,813.81	$5,653.32	$4,310.88	$2,809.05
	Child Only	$1,192.43	$985.01	$817.25	$623.19	N/A
Syracuse	Individual	$2,893.01	$2,389.79	$1,982.78	$1,511.95	$985.21
	Individual & Spouse	$5,786.02	$4,779.58	$3,965.56	$3,023.90	$1,970.42
	Parent & Child(ren)	$4,918.12	$4,062.64	$3,370.73	$2,570.32	$1,674.86
	Family	$8,245.08	$6,810.90	$5,650.92	$4,309.06	$2,807.85
	Child Only	$1,191.92	$984.59	$816.91	$622.92	N/A
Utica/Watertown	Individual	$2,893.01	$2,389.79	$1,982.78	$1,511.95	$985.21
	Individual & Spouse	$5,786.02	$4,779.58	$3,965.56	$3,023.90	$1,970.42
	Parent & Child(ren)	$4,918.12	$4,062.64	$3,370.73	$2,570.32	$1,674.86
	Family	$8,245.08	$6,810.90	$5,650.92	$4,309.06	$2,807.85
	Child Only	$1,191.92	$984.59	$816.91	$622.92	N/A

Listed below are the monthly premium rates **with age 29 rider**, which extends coverage for adult children through age 29 (up to 30th birthday).

		EmblemHealth Platinum Age 29	EmblemHealth Gold Age 29	EmblemHealth Silver Age 29	EmblemHealth Bronze Age 29
Albany	Individual	$2,979.80	$2,461.48	$2,042.26	$1,557.31
	Individual & Spouse	$5,959.60	$4,922.96	$4,084.52	$3,114.62
	Parent & Child(ren)	$5,065.66	$4,184.52	$3,471.84	$2,647.43
	Family	$8,492.43	$7,015.22	$5,820.44	$4,438.33
Mid-Hudson	Individual	$2,981.07	$2,462.53	$2,043.13	$1,557.97
	Individual & Spouse	$5,962.14	$4,925.06	$4,086.26	$3,115.94
	Parent & Child(ren)	$5,067.82	$4,186.30	$3,473.32	$2,648.55
	Family	$8,496.05	$7,018.21	$5,822.92	$4,440.21
Syracuse	Individual	$2,979.80	$2,461.48	$2,042.26	$1,557.31
	Individual & Spouse	$5,959.60	$4,922.96	$4,084.52	$3,114.62
	Parent & Child(ren)	$5,065.66	$4,184.52	$3,471.84	$2,647.43
	Family	$8,492.43	$7,015.22	$5,820.44	$4,438.33
Utica/Watertown	Individual	$2,979.80	$2,461.48	$2,042.26	$1,557.31
	Individual & Spouse	$5,959.60	$4,922.96	$4,084.52	$3,114.62
	Parent & Child(ren)	$5,065.66	$4,184.52	$3,471.84	$2,647.43
	Family	$8,492.43	$7,015.22	$5,820.44	$4,438.33

Albany: Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schoharie, Schenectady, Warren, Washington

Mid-Hudson: Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster

Syracuse: Broome

Utica/Watertown: Otsego

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 פֿראַווייַדינג 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.

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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۔ (**711** :TTY) **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**.

Notes

Notes

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EmblemHealth®

For more information, visit us at
emblemhealth.com/individualsandfamilies
or call us at **866-838-9144** (TTY: **711**).

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