# EmblemHealth Select Care Gold D
## Summary of Benefits
## Select Care Network - Referral Required

PHGLDB021 / MH001386

| **Deductible and Out-of-Pocket Maximum** | **In-Network (INET)**<br>**Member Pays** |
|---|---|
| **Plan deductible** | $1,200<br>$2,400 |
| **Separate Prescription Drug Deductible** | None |
| **Out-of-Pocket Maximum** | $12,000<br>$24,000 |
| **Benefits** | **In-Network (INET)**<br>**Member Pays** |
| **Provider Office Visits** | |
| **Mental Health and Substance Abuse Office Visits** | Office Visits: $25 copayment after deductible<br>All Other Outpatient Services: $25 copayment after deductible |
| **ABA Treatment for Autism Spectrum Disorder**<br>Preauthorization required. | $25 copayment after deductible |
| **Primary Care Provider Office Visits**<br>(includes services for illness, injury, follow-up care and consultations) | $25 copayment after deductible |
| **Specialist Office Visits**<br>Referral required. | $40 copayment after deductible |
| **Preventive Office Visits** | |
| **Adult/Pediatric Preventive Visits** | No Charge |
| **Prenatal Care** | No Charge |
| **Routine Gynecological Services/Well Woman Exams, Mammography Screenings*** | No Charge |
| **Well-Baby and Well-Child Care, including Immunizations*** | No Charge |
| **All other preventive services*** | No Charge |

| Benefits | In-Network (INET)<br>Member Pays |
|---|---|
| ***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) |
| **Vasectomy** | See surgical services |
| **All other preventive services required by USPSTF and HRSA** | No Charge |
| **Outpatient Diagnostic Services** | |
| **Advanced Radiology**<br>(CT/PET Scan, MRI)<br>Preauthorization required. | $40 copayment after deductible |
| **Laboratory Services**<br>Preauthorization required. | Performed in a PCP Office: $25 copayment after deductible<br>Performed in a Specialist Office: $40 copayment after deductible |
| **Non-Advanced Radiology**<br>(X-ray, Diagnostic)<br>Preauthorization may be required. | $40 copayment after deductible |
| **Preadmission Testing**<br>Preauthorization required. | $0 copayment after deductible |
| **Second Opinions on the Diagnosis of Cancer, Surgery and Other**<br>Referral required. | $40 copayment after deductible |
| **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**<br>Tier 1 | $10 copayment not subject to deductible |
| **Non-preferred Generic**<br>Tier 2 | $35 copayment not subject to deductible |
| **Preferred Brand**<br>Tier 3 | $70 copayment not subject to deductible |
| **Prescription – Mail Order Pharmacy (up to a 90-day supply per prescription)** | |
| **Preferred Generic**<br>Tier 1 | $25 copayment not subject to deductible |
| **Non-preferred Generic**<br>Tier 2 | $87.50 copayment not subject to deductible |
| **Preferred Brand**<br>Tier 3 | $175 copayment not subject to deductible |
| **Outpatient Rehabilitative and Habilitative Services** | |

| Benefits | In-Network (INET)<br>Member Pays |
|---|---|
| **Physical and Occupational Therapy**<br>60 visits per condition/plan year, combined therapies. | $30 copayment after deductible |
| **Other Services** | |
| **Anesthesia Services** | No Charge |
| **Cardiac and Pulmonary Rehabilitation**<br>Preauthorization required for Inpatient services. | $25 copayment after deductible |
| **Chemotherapy** | $25 copayment after deductible |
| **Chiropractic Services** | $40 copayment after deductible |
| **Diabetic Equipment and Supplies**<br>90-day supply mail order available. Preauthorization may be required. | $25 copayment after deductible per 30-day supply. Insulin covered in full. |
| **Dialysis**<br>Referral required. | $25 copayment after deductible |
| **Durable Medical Equipment**<br>Preauthorization required. | 20% coinsurance after deductible |
| **External Hearing Aids**<br>Single purchase once every 3 years. Preauthorization required. | 20% coinsurance after deductible |
| **Home Health Care**<br>40 visits per plan year. Preauthorization required. | $25 copayment after deductible |
| **Outpatient Services**<br>(in a hospital or ambulatory facility)<br>Preauthorization may be required. | $100 copayment after deductible |
| **Inpatient Services** | |
| **Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility and all IP settings**<br>Preauthorization required, except for emergency admissions. | $1,000 copayment after deductible, per admission |
| **Inpatient Rehabilitation Services**<br>60 days per condition/plan year, combined therapies.<br>Preauthorization required. | $1,000 copayment after deductible, per admission |

| Benefits | In-Network (INET)<br>Member Pays |
|---|---|
| **Inpatient Habilitation Services**<br>60 days per condition/plan year, combined therapies.<br>Preauthorization required. | $1,000 copayment after deductible, per admission |
| **Emergency and Urgent Care** | |
| **Ambulance Services** | $150 copayment after deductible |
| **Emergency Room**<br>Waived if admitted to Hospital. | $150 copayment after deductible |
| **Urgent Care Centers** | $60 copayment after deductible |
| **Pediatric Dental Care - up to age 19 end of month** | |
| **Preventive Dental Care**<br>1 dental exam and cleaning per 6-month period. | $25 copayment after deductible |
| **Routine Dental Care**<br>Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at 6-month intervals. | $25 copayment after deductible |
| **Major Dental Care**<br>Preauthorization required. | $25 copayment after deductible |
| **Orthodontia**<br>Preauthorization required. | $25 copayment after deductible |
| **Pediatric Vision Care - up to age 19 end of month** | |
| **Contact Lens**<br>1 set of prescribed lenses and frames per 12-month period. | 20% coinsurance after deductible |
| **Prescription Eye Glasses**<br>1 set of prescribed lenses and frames per 12-month period. | 20% coinsurance after deductible |
| **Routine Eye Exam**<br>1 exam per 12-month period. | $25 copayment after deductible |
| **Additional Covered Services** | |
| **Allergy Testing**<br>Referral required. | Performed in a PCP Office: $25 copayment after deductible<br>Performed in a Specialist Office: $40 copayment after deductible |
| **Gym Reimbursement**<br>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) |

## Important information

EmblemHealth 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 Select Care network 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 policy form number 155-23-IOFFHIXSelectGSchedule (04/26), 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.

Dialysis performed by non-participating providers is limited to 10 visits per calendar year. Preauthorization required.

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**.