

Section XXVIII

EmblemHealth Platinum Schedule of Benefits

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Deductible <ul style="list-style-type: none"> • Individual • Family Out-of-Pocket Limit <ul style="list-style-type: none"> • Individual • Family 	\$0 \$0	None None	
	\$2,000 \$4,000	Non-Participating Provider services are not Covered except as required for emergency care.	
OFFICE VISITS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	\$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits) Referral required	\$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<ul style="list-style-type: none"> • Well Child Visits and Immunizations* • Adult Annual Physical Examinations* • Adult Immunizations* • Routine Gynecological Services/Well Woman Exams* • Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer • (1)[Sterilization Procedures for Women*] • (2)[Vasectomy] • Bone Density Testing* • Screening for Prostate Cancer <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>[Covered in full]</p> <p>[See Surgical Services Cost-Sharing]</p> <p>Covered in full</p> <p>\$15 Copayment</p> <p>\$35 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>[Non-Participating Provider services are not Covered and You pay the full cost]</p> <p>[Non-Participating Provider services are not Covered and You pay the full cost]</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

PREVENTIVE CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<ul style="list-style-type: none"> All other preventive services required by USPSTF and HRSA *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA 	<p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description
EMERGENCY CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$100 Copayment	\$100 Copayment	See benefit for description
Non-Emergency Ambulance Services	\$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization required			
Emergency Department	\$100 Copayment	\$100 Copayment	See benefit for description
Copayment waived if Hospital admission			
Urgent Care Center	\$55 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Advanced Imaging Services</p> <ul style="list-style-type: none"> Performed in a Specialist Office Performed in a Freestanding Radiology Facility Performed as Outpatient Hospital Services <p>Referral required</p>	<p>\$35 Copayment</p> <p>\$35 Copayment</p> <p>\$35 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Allergy Testing and Treatment</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office <p>Referral required</p>	<p>\$15 Copayment</p> <p>\$35 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Ambulatory Surgical Center Facility Fee</p> <p>Preauthorization required</p>	<p>\$100 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Anesthesia Services (all settings)</p>	<p>Covered in full</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Autologous Blood Banking</p> <p>Preauthorization required</p>	<p>10% Coinsurance</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Cardiac and Pulmonary Rehabilitation <ul style="list-style-type: none"> • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services <p>Preauthorization required</p>	\$15 Copayment \$15 Copayment Included as part of inpatient Hospital service Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Included as part of inpatient Hospital service Cost-Sharing	See benefit for description
Chemotherapy <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services <p>Referral required</p>	\$15 Copayment \$15 Copayment \$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Chiropractic Services	\$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Clinical Trials <p>Preauthorization required</p>	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diagnostic Testing <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office Referral required • Performed as Outpatient Hospital Services Referral required 	\$15 Copayment \$35 Copayment \$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Dialysis <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office Referral required • Performed in a Freestanding Center Referral required • Performed as Outpatient Hospital Services Referral required 	\$15 Copayment \$15 Copayment \$15 Copayment \$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description Dialysis performed by Non-Participating Providers is limited to ten (10) visits per calendar year Preauthorization required
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) Preauthorization required	\$25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Sixty (60) visits per condition, per Plan Year combined therapies
Home Health Care Preauthorization required	\$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Forty (40) visits per Plan Year

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Infertility Services Preauthorization required	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and Diagnostic Procedures)	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Infusion Therapy <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Referral required Performed as Outpatient Hospital Services Referral required Home Infusion Therapy Preauthorization required 	\$15 Copayment \$15 Copayment \$15 Copayment \$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description Home infusion counts toward home health care visit limits
Inpatient Medical Visits	\$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Laboratory Procedures <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed in a Freestanding Laboratory Facility Performed as Outpatient Hospital Services 	\$15 Copayment \$35 Copayment \$35 Copayment \$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Maternity and Newborn Care</p> <ul style="list-style-type: none"> • Prenatal Care <ul style="list-style-type: none"> • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Inpatient Hospital Services and Birthing Center • Physician and Midwife Services for Delivery • Breastfeeding Support, Counseling and Supplies, including Breast Pumps • Postnatal Care <p>Preauthorization required for inpatient services; breast pump</p>	<p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p> <p>\$500 Copayment</p> <p>\$100 Copayment</p> <p>Covered in full</p> <p>Covered in full</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p> <p>One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Outpatient Hospital Surgery Facility Charge Preauthorization required	\$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing Preauthorization required	\$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prescription Drugs Administered in Office <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office 	Included as part of the PCP office visit Cost-Sharing Included as part of the Specialist office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diagnostic Radiology Services <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office Preauthorization required • Performed in a Freestanding Radiology Facility Preauthorization required • Performed as Outpatient Hospital Services Preauthorization required 	\$15 Copayment \$35 Copayment \$35 Copayment \$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Therapeutic Radiology Services <ul style="list-style-type: none"> • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services <p>Referral required</p>	\$15 Copayment \$15 Copayment \$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <p>Preauthorization required</p>	\$25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Sixty (60) visits per condition, per Plan Year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery and Other <p>Referral required</p>	\$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)</p> <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office <p>Preauthorization required</p>	<p>\$100 Copayment</p> <p>\$100 Copayment</p> <p>\$100 Copayment</p> <p>\$15 Copayment</p> <p>\$35 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p> <p>All transplants must be performed at designated Facilities</p>

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Telemedicine Program <ul style="list-style-type: none"> • Provided by a Telemedicine Physician • Provided by a Dietitian/Nutritionist 	\$0 Copayment \$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder Preauthorization required	\$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder Preauthorization required	\$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education <ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-day supply) • Diabetic Education Preauthorization required	\$15 Copayment \$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Durable Medical Equipment and Braces Preauthorization required	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

ADDITIONAL SERVICES, EQUIPMENT and DEVICES – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
External Hearing Aids Preauthorization required	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	Single purchase once every three (3) years
Cochlear Implants Preauthorization required	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered
Hospice Care <ul style="list-style-type: none"> • Inpatient • Outpatient Preauthorization required	\$500 Copayment \$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	Two hundred ten (210) days per Plan Year Five (5) visits for family bereavement counseling
Medical Supplies Preauthorization required	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prosthetic Devices <ul style="list-style-type: none"> • External • Internal Preauthorization required	10% Coinsurance Included as part of inpatient Hospital Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements Unlimited; See benefit for description

INPATIENT SERVICES and FACILITIES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) Preauthorization required. However, Preauthorization is not required for emergency admissions.	\$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Observation Stay	\$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) Preauthorization required	\$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Two hundred (200) days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) Preauthorization required	\$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Sixty (60) days per Plan Year combined therapies
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) Preauthorization required	\$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Sixty (60) days per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital stay or surgery

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care including Residential Treatment (for a continuous confinement when in a Hospital) Preauthorization required. However, Preauthorization is not required for emergency admissions.	\$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	\$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Inpatient Substance Use Services including Residential Treatment (for a continuous confinement when in a Hospital) Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.	\$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)	\$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited; Up to twenty (20) visits per Plan Year may be used for family counseling
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy.	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits

PRESCRIPTION DRUGS – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
30-day supply Tier 1	\$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$30 Copayment		
Tier 3	\$60 Copayment		
If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of 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.			
Mail Order Pharmacy			
Up to a 90-day supply Tier 1	\$25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$75 Copayment		
Tier 3	\$150 Copayment		
Enteral Formulas Tier 1	\$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$30 Copayment		
Tier 3	\$60 Copayment		
WELLNESS BENEFITS			
Gym Reimbursement	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse

VISION CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Vision Care <ul style="list-style-type: none"> • Exams • Lenses and Frames • Contact Lenses 	\$15 Copayment 10% Coinsurance 10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	One (1) exam per twelve (12) month period; One (1) prescribed lenses and frames per twelve (12) month period
DENTAL CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care <ul style="list-style-type: none"> • Emergency Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery) • Orthodontics Major Dental Care and Orthodontics require Preauthorization 	\$15 Copayment \$15 Copayment \$15 Copayment \$15 Copayment \$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	 One (1) dental exam and cleaning per six (6) month period Full mouth x-rays or panoramic x-rays at thirty-six (36) month intervals and bitewing x-rays at six (6) month intervals

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Certificate, You will be responsible for the full cost of the services.



ATTENTION: Language assistance services, free of charge, are available to you. Call **1-877-411-3625** (TTY/TDD: **711**).

Español (Spanish)

ATENCIÓN: Usted tiene a su disposición, gratis, servicios de ayuda para idiomas. Llame al **1-877-411-3625** (TTY/TDD: **711**).

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)

ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика. Звоните по тел. **1-877-411-3625** (служба текстового телефона TTY/TDD: **711**).

Kreyòl Ayisyen (Haitian Creole)

ATANSYON: Gen sèvis èd nan lang gratis ki disponib pou ou. Rele nimewo **1-877-411-3625** (TTY/TDD: **711**).

한국어 (Korean)

주의: 귀하에게 언어 지원 서비스가 무료로 제공됩니다. **1-877-411-3625**(TTY/TDD: **711**)번으로 전화하십시오.

Italiano (Italian)

ATTENZIONE: sono disponibili servizi gratuiti di assistenza linguistica. Chiami il numero **1-877-411-3625** (TTY/TDD: **711**).

אידיש (Yiddish)

אכטונג: שפראך הילף סערוויסעס, אהן קיין פרייז, זיינען דא צו באקומען פאר אייך. רופט **1-877-411-3625** (TTY/TDD: **711**).

বাংলা (Bengali)

মনোযোগ দিন: ভাষা সহায়তা পরিষেবাগুলি আপনার জন্য বিনামূল্যে উপলব্ধ আছে। **1-877-411-3625** (TTY/TDD: **711**) নম্বরে ফোন করুন।

Polski (Polish)

UWAGA: dostępna jest bezpłatna pomoc językowa. Prosimy zadzwonić pod numer **1-877-411-3625** (TTY/TDD: **711**).

العربية (Arabic)

يرجى الانتباه: تتوفر لك خدمات المساعدة اللغوية مجاناً، اتصل على الرقم **1-877-411-3625** أو (TTY/TDD: **711**).

Français (French)

ATTENTION : une assistance d'interprétation gratuite est à votre disposition. Veuillez composer le **1-877-411-3625** (TTY/TDD : **711**).

وجہ دیں: آپ کے لیے زبان سے متعلق اعانت کی خدمات، مفت دستیاب ہیں۔ 1-877-411-3625 (TTY/TDD: 711) پر کال کریں۔

Tagalog (Tagalog)

NANANAWAGAN NG PANSIN: Mayroon kang magagamit na mga serbisyo para sa tulong sa wika nang walang bayad. Tawagan ang **1-877-411-3625** (TTY/TDD: **711**).

Ελληνικά (Greek)

ΠΡΟΣΟΧΗ: Διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε το **1-877-411-3625** (για άτομα με προβλήματα ακοής (TTY/TDD): **711**).

Shqip (Albanian)

VINI RE: Shërbime ndihmore për gjuhën, falas, janë në dispozicionin tuaj. Telefononi në **1-877-411-3625** (TTY/TDD: **711**).

NOTICE OF NONDISCRIMINATION POLICY

EmblemHealth complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. EmblemHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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**).

If you believe that EmblemHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with EmblemHealth Grievance and Appeals Department, PO Box 2844, New York, NY 10116, or call member services at **1-877-411-3625**. (Dial **711** for TTY/TDD services.) You can file a grievance in person, by mail or by phone. 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 of Civil Rights electronically through the Office of 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; 1-800-368-1019**, (dial **1-800-537-7697** for TTY services).

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