# EmblemHealth® SUMMARY OF BENEFITS

## EmblemHealth Gold P.O.S

### Prime - No Referral Required

[PPGLDS001] / [MS001001]

| COST-SHARING | COMMENTS / LIMITATIONS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|---|
| Deductible<br>Individual<br>Family | Applies to hospital, medical, dental and vision | <br>$1,000 per plan year<br>$2,000 per plan year | <br>$3,800 per plan year<br>$7,600 per plan year |
| Prescription Drug Deductible | | $0 per plan year | Not applicable |
| Out-of-Pocket Maximum<br>Individual<br>Family | | <br>$5,000 per plan year<br>$10,000 per plan year | <br>$7,000 per plan year<br>$14,000 per plan year |
| **OFFICE VISITS** | | | |
| Primary Care Physician Office Visit | 3 visits covered in full (in-network only) | $25 copayment not subject to deductible | 40% coinsurance after deductible |
| Specialist Care Physician Office Visit | | $40 copayment not subject to deductible | 40% coinsurance after deductible |
| Telemedicine<br>Physician | | Covered in full | Not applicable |
| **PREVENTIVE CARE SERVICES** | | | |
| Well-Baby and Well-Child Care, including Immunizations* | | Covered in full | 40% coinsurance after deductible |
| Adult Annual Physical Checkup and Adult Immunizations* | | Covered in full | 40% coinsurance after deductible |
| Routine Gynecological Services/Well Woman Exams, Mammography Screenings* | | Covered in full | 40% coinsurance after deductible |
| Vasectomy | | See surgical services below | See surgical services below |
| All other preventive services* | | Covered in full | 40% coinsurance after deductible |
| *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF or HRSA | | See applicable service type | See applicable service type |
| **EMERGENCY CARE** | | | |
| Emergency Room | Copayment waived if admitted to hospital | 30% coinsurance after deductible | 30% coinsurance after deductible |
| Urgent Care Center | | $75 copayment not subject to deductible | 40% coinsurance after deductible |
| Ambulance | | 30% coinsurance not subject to deductible | 30% coinsurance not subject to deductible |
| **PROFESSIONAL SERVICES and OUTPATIENT CARE** | | | |
| Acupuncture | 12 visits per plan year | Covered in full | Not applicable |
| Advanced Imaging | Prior approval required In-network and Out-of-Network. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less. | $40 copayment after deductible | 40% coinsurance after deductible |
| Allergy Care<br>Performed in PCP Office<br>Performed in Specialist Office | | <br>$25 copayment after deductible<br>$40 copayment after deductible | <br>40% coinsurance after deductible<br>40% coinsurance after deductible |
| Ambulatory Surgical Facility | Prior approval required In-network and Out-of-Network. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less. | $200 copayment after deductible | 40% coinsurance after deductible |
| Anesthesia Services (all settings) | | Covered in full | 40% coinsurance after deductible |
| Cardiac and Pulmonary Rehabilitation | Prior approval required In-network and Out-of-Network. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less. | $40 copayment after deductible | 40% coinsurance after deductible |

| PROFESSIONAL SERVICES and OUTPATIENT CARE cont'd | | | |
|---|---|---|---|
| Chemotherapy<br>Performed in PCP Office<br>Performed in Specialist Office | Prior approval required In-network and Out-of-Network. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less. | $25 copayment after deductible<br>$40 copayment after deductible | 40% coinsurance after deductible<br>40% coinsurance after deductible |
| Chiropractic Services | | $40 copayment not subject to deductible | 40% coinsurance after deductible |
| Diagnostic Testing<br>Performed in PCP Office<br>Performed in Specialist Office | Prior approval required In-network and Out-of-Network for Outpatient services. Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less. | $25 copayment after deductible<br>$40 copayment after deductible | 40% coinsurance after deductible<br>40% coinsurance after deductible |
| Dialysis<br>Performed in PCP Office<br>Performed in Specialist Office | | $25 copayment after deductible<br>$40 copayment after deductible | 40% coinsurance after deductible<br>40% coinsurance after deductible |
| Habilitation and Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)<br>Performed in PCP Office<br>Performed in Specialist Office | Prior approval required In-network and Out-of-Network. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less. Combined 60 visits/condition/plan year Occupational, Physical and Speech. Speech and physical therapy for rehabilitation are only covered following a hospital stay or surgery Unlimited visits/year Cardiac and Respiratory | $25 copayment after deductible<br>$40 copayment after deductible | 40% coinsurance after deductible<br>40% coinsurance after deductible |
| Home Health Care | Prior approval required In-network and Out-of-Network. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less. 40 visits per plan year | $40 copayment after deductible | 40% coinsurance after deductible |
| Laboratory Procedures<br>Performed in PCP Office<br>Performed in Specialist Office | Prior approval required In-network and Out-of-Network for Outpatient services. Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less. | $25 copayment after deductible<br>$40 copayment after deductible | 40% coinsurance after deductible<br>40% coinsurance after deductible |
| Maternity and Newborn Care<br>Inpatient Hospital and Birthing Center<br>Prenatal Care | Prior approval required In-network and Out-of-Network for Inpatient services. Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less. | 30% coinsurance after deductible<br>Covered in full | 40% coinsurance after deductible<br>40% coinsurance after deductible |
| Preadmission Testing | Prior approval required In-network and Out-of-Network. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less | $0 not subject to deductible | 30% coinsurance after deductible |
| Diagnostic Radiology Services<br>Performed in PCP Office<br>Performed in Specialist Office | Prior approval required In-network and Out-of-Network. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less | $25 copayment after deductible<br>$40 copayment after deductible | 40% coinsurance after deductible<br>40% coinsurance after deductible |
| Second Opinions on the Diagnosis of Cancer, Surgery and Other | | $40 copayment after deductible | 40% coinsurance after deductible |
| Surgical Services<br>Surgical Services in In-Patient/Out-Patient Facility<br>PCP Office Surgery<br>Specialist Office Surgery | Prior approval required In-network and Out-of-Network. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less | $200 copayment after deductible<br>$25 copayment after deductible<br>$40 copayment after deductible | 40% coinsurance after deductible<br>40% coinsurance after deductible<br>40% coinsurance after deductible |

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|---|---|---|---|
| **ADDITIONAL SERVICES, EQUIPMENT and DEVICES** | | | |
| Diabetic Equipment, Supplies and Insulin | Prior approval required In-network and Out-of-Network. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less | $25 copayment not subject to deductible, per 30-day supply | $60 copayment not subject to deductible, per 30-day supply |
| Durable Medical Equipment | Preauthorization required. One external prosthetic device per limb per lifetime with coverage for repairs and replacement. No orthotics. | 20% coinsurance after deductible | Not applicable |
| External Hearing Aids | Preauthorization required. Single purchase, once every three years. | 20% coinsurance after deductible | Not applicable |
| Inpatient Hospice Care | Preauthorization required.<br>210 days per plan year | 30% coinsurance after deductible | Not applicable |
| **INPATIENT SERVICES and FACILITIES** | | | |
| Inpatient Hospital Service | Prior approval required In-network and Out-of-Network, except for emergency admissions. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less. | 30% coinsurance after deductible | 40% coinsurance after deductible |
| Skilled Nursing Facility Care | Preauthorization required.<br>200 days per plan year | 30% coinsurance after deductible | Not applicable |
| Inpatient Rehabilitation Services<br>(Physical, Speech and Occupational Therapy) | Prior approval required In-network and Out-of-Network. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less. 60 days per plan year, combined therapies. Speech and physical therapy are only covered following a hospital stay or surgery | 30% coinsurance after deductible | 40% coinsurance after deductible |
| Inpatient Habilitation Services<br>(Physical, Speech and Occupational Therapy) | Prior approval required In-network and Out-of-Network. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less. 60 days per plan year, combined therapies | 30% coinsurance after deductible | 40% coinsurance after deductible |
| **MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES** | | | |
| Inpatient Mental Health Care | Prior approval required In-network and Out-of-Network, except for emergency admissions or for admission at Participating OHM-licensed Facilities for Members under 18. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less. | 30% coinsurance after deductible | 40% coinsurance after deductible |
| Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) | | $25 copayment not subject to deductible | 40% coinsurance after deductible |
| Inpatient Substance Use Services | Prior approval required In-network and Out-of-Network, except for emergency admissions or for Participating OASAS-certified Facilities. If you do not get prior approval for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less. | 30% coinsurance after deductible | 40% coinsurance after deductible |
| Outpatient Substance Use Services | Up to 20 visits per plan year may be used for family counseling. | $25 copayment not subject to deductible | 40% coinsurance after deductible |

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|---|---|---|---|
| **PERSCRIPTION DRUGS** | | | |
| Retail Pharmacy<br>Tier 1<br>Tier 2<br>Tier 3 | 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. Ancillary charges apply, per your Member Contract. Your cost may be higher if you select a brand name drug when a generic medicine is available. This plan has a Preferred Pharmacy Network which excludes CVS. | $0 copayment<br>$35 copayment<br>$75 copayment | Not applicable |
| Mail Order Pharmacy<br>Tier 1<br>Tier 2<br>Tier 3 | | $0 copayment<br>$87.50 copayment<br>$187.50 copayment | Not applicable |
| **WELLNESS BENEFIT** | | | |
| Gym Reimbursement | Gym reimbursement benefit does not apply towards the deductible or out of pocket maximum | Subscriber reimbursed up to $200 for completion of 50 exercise facility visits in each six-month period<br>Covered spouse reimbursed up to $100 per six-month period and 50 visits | Subscriber reimbursed up to $200 for completion of 50 exercise facility visits in each six-month period<br>Covered spouse reimbursed up to $100 per six-month period and 50 visits |
| **PEDIATRIC VISION CARE -- Pediatric coverage up to age 19 end of month** | | | |
| Exams | One exam per 12-month period. | $0 copayment not subject to deductible | Not applicable |
| Frames | One set of provider designated frames per 12-month period. | 20% coinsurance not subject to deductible* | Not applicable |
| Standard Plastic Lenses Single Vision<br>Bifocal Trifocal Lenticular<br>Standard Progressive Lens | One set of lenses or provider designated contacts per 12-month period. | 20% coinsurance not subject to deductible* | Not applicable |
| Contact Lenses<br>Conventional<br>Disposable<br>Medically Necessary | 1 pair from selection of provider designated contacts<br>Up to 6 mos. supply of 2-week disposables, single vision spherical or toric contact lenses<br>Paid in full | 20% coinsurance not subject to deductible* | Not applicable |
| **PEDIATRIC DENTAL CARE-- Pediatric coverage up to age 19 end of month** | | | |
| Emergency Dental Care | | $25 copayment not subject to deductible | Not applicable |
| Preventive Dental Care | One dental exam and cleaning per 6-month period | $0 copayment not subject to deductible | Not applicable |
| Routine Dental Care | Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at 6-month intervals | $25 copayment not subject to deductible | Not applicable |
| Major Dental Care - Pediatric Only<br>(Endodontics, Periodontics, Prosthodontics and Oral Surgery) | Requires preauthorization | $40 copayment not subject to deductible | Not applicable |
| Orthodontics - Pediatric Only | Requires preauthorization | $40 copayment not subject to deductible | Not applicable |

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

Participating physicians and providers have contracted with EmblemHealth to provide care to our members; they are not employees, agents, servants or representatives of EmblemHealth. This summary is provided for information only; it does not contain complete details or limitations of the Plan which are available only in the Contract or Certificate of Coverage/Insurance, and it does not constitute an agreement.

Refer to HIP policy form number 155-OA-NSSGSilverValueSSch (04/19), et al.

Certain services must be approved in advance by EmblemHealth.

Second opinions on diagnosis of cancer are covered at participating cost sharing for non-participating Specialist, no referral required.

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

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

* Please note the member responsibility amount for covered services will be calculated based on the provider allowed charge.

EmblemHealth

# 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 مجانا، 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**).



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**اردو (Urdu)**
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**.