



SUMMARY OF BENEFITS

Gold EPO Virtual-M

Millennium – No Referral Required

PEGDVM001 / ME000167

COST-SHARING	COMMENTS / LIMITATIONS	Preferred Virtual ACPNY	Participating Millennium Network
Deductible Individual Family	Applies to hospital, medical, dental and vision and pharmacy	\$0 per plan year \$0 per plan year	\$1,700 per plan year \$3,400 per plan year
Out-of-Pocket Maximum Individual Family			\$8,200 per plan year \$16,400 per plan year
OFFICE VISITS			
Primary Care Physician Office Visit		Not applicable	\$40 copayment not subject to deductible
Specialist Care Physician Office Visit		N/A	\$60 copayment not subject to deductible
Telemedicine Physician		Not applicable	Not applicable
PREVENTIVE CARE SERVICES			
Well-Baby and Well-Child Care, including Immunizations*		Not applicable	Covered in full
Adult Annual Physical Checkup and Adult Immunizations*		Not applicable	Covered in full
Routine Gynecological Services/Well Woman Exams, Mammography Screenings*		Not applicable	Covered in full
Vasectomy		See surgical services below	See surgical services below
All other preventive services*		Not applicable	Covered in full
*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	Not applicable	40% coinsurance after deductible
Urgent Care Center		Not applicable	\$75 copayment not subject to deductible
Ambulance		Not applicable	\$350 copayment after deductible
PROFESSIONAL SERVICES and OUTPATIENT CARE			
Acupuncture	12 visits per plan year	Not applicable	Covered in full
Advanced Imaging	Prior approval required for Outpatient services	Not applicable	\$60 copayment after deductible
Allergy Care Performed in PCP Office Performed in Specialist Office		Not applicable Not applicable	\$40 copayment after deductible \$60 copayment after deductible
Ambulatory Surgical Facility	Prior approval required	Not applicable	\$350 copayment after deductible
Anesthesia Services (all settings)		Not applicable	Covered in full
Cardiac and Pulmonary Rehabilitation	Prior approval required	Not applicable	\$60 copayment after deductible

PROFESSIONAL SERVICES and OUTPATIENT CARE (con't)			
Chemotherapy Performed in PCP Office Performed in Specialist Office	Prior approval required	Not applicable Not applicable	\$40 copayment not subject to deductible \$60 copayment not subject to deductible
Chiropractic Services		Not applicable	\$60 copayment not subject to deductible
Diagnostic Testing Performed in PCP Office Performed in Specialist Office	Prior approval required for Outpatient services	Not applicable Not applicable	\$40 copayment after deductible \$60 copayment after deductible
Dialysis Performed in PCP Office Performed in Specialist Office		Not applicable Not applicable	\$40 copayment after deductible \$60 copayment after deductible
Habilitation and Rehabilitation Services (Physical, Speech, or Occupational Therapy) Performed in PCP Office Performed in Specialist Office	Prior approval required. 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	Not applicable Not applicable	\$40 copayment after deductible \$60 copayment after deductible
Home Health Care	Prior approval required. 40 visits per plan year	Not applicable	\$60 copayment after deductible
Laboratory Procedures Performed in PCP Office Performed in Specialist Office	Prior approval required for Outpatient services	\$0 copayment Not Applicable	\$0 copayment not subject to deductible \$60 copayment not subject to deductible
Maternity and Newborn Care Inpatient Hospital and Birthing Center Prenatal Care	Prior approval required for Inpatient services	Not applicable Not applicable	40% coinsurance after deductible Covered in full
Preadmission Testing	Prior approval required	Not applicable	\$0 copayment not subject to deductible
Diagnostic Radiology Services Performed in PCP Office Performed in Specialist Office	Prior approval required	Not applicable Not applicable	\$40 copayment after deductible \$60 copayment after deductible
Second Opinions on the Diagnosis of Cancer, Surgery and Other		Not applicable	\$60 copayment after deductible
Surgical Services Surgical Services in In-Patient/Out-Patient Facility PCP Office Surgery Specialist Office Surgery	Prior approval required	Not applicable Not applicable Not applicable	\$350 copayment after deductible \$40 copayment after deductible \$60 copayment after deductible

ADDITIONAL SERVICES, EQUIPMENT and DEVICES			
Diabetic Equipment, Supplies and Insulin	Prior approval required	Not applicable	\$40 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.	Not applicable	Not applicable
External Hearing Aids	Preauthorization required. Single purchase, once every three years.	Not applicable	Not applicable
Inpatient Hospice Care	Preauthorization required. 210 days per plan year	Not applicable	30% coinsurance after deductible
INPATIENT SERVICES and FACILITIES			
Inpatient Hospital Service	Prior approval required	Not applicable	30% coinsurance after deductible, per admission
Skilled Nursing Facility Care	Preauthorization required. 200 days per plan year	Not applicable	30% coinsurance after deductible, per admission
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	Prior approval required. 60 days per plan year, combined therapies. Speech and physical therapy are only covered following a hospital stay or surgery	Not applicable	30% coinsurance after deductible, per admission
Inpatient Habilitation Services (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	Not applicable	30% coinsurance after deductible, per admission
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES			
Inpatient Mental Health Care	Prior approval required, except for emergency admissions or for admission at Participating OHM-licensed Facilities for Members under 18.	Not applicable	30% coinsurance after deductible, per admission
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)		Not applicable	\$40 copayment not subject to deductible
Inpatient Substance Use Services	Prior approval required, except for Emergency Admissions or for Participating OASAS-certified Facilities	Not applicable	30% coinsurance after deductible, per admission
Outpatient Substance Use Services	Up to 20 visits per plan year may be used for family counseling.	Not applicable	\$40 copayment not subject to deductible

PRESCRIPTION DRUGS			
Retail Pharmacy Tier 1 Tier 2 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 \$40 copayment \$80 copayment	\$0 copayment not subject to deductible \$40 copayment not subject to deductible \$80 copayment not subject to deductible
Mail Order Pharmacy Tier 1 Tier 2 Tier 3		\$0 copayment \$100 copayment \$200 copayment	\$0 copayment not subj. to deductible \$100 copayment not subj. to deductible \$200 copayment not subj. to deductible
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 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 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.	Not applicable	\$0 copayment not subject to deductible
Frames	One set of provider-designated frames per 12-month period.	Not applicable	20% coinsurance not subject to deductible
Standard Plastic Lenses Single Vision Bifocal Trifocal Lenticular Standard Progressive Lens	One set of lenses or provider designated contacts per 12-month period.	Not applicable	20% coinsurance not subject to deductible
Contact Lenses Conventional Disposable Medically Necessary	1 pair from selection of provider designated contacts Up to 6 mos. supply of 2- week disposables, single vision spherical or toric contact lenses Paid in full	Not applicable	20% coinsurance not subject to deductible
PEDIATRIC DENTAL CARE-- Pediatric coverage up to age 19 end of month			
Emergency Dental Care		Not applicable	\$40 copayment not subject to deductible
Preventive Dental Care	One dental exam and cleaning per 6-month period	Not applicable	\$0 copayment not subject to deductible
Routine Dental Care	Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at 6-month intervals	Not applicable	\$40 copayment not subject to deductible
Major Dental Care - Pediatric Only (Endodontics, Periodontics, Prosthodontics and Oral 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.	Not applicable	\$60 copayment not subject to deductible
Orthodontics - Pediatric Only	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.	Not applicable	\$60 copayment not subject to deductible

This EmblemHealth Plan is underwritten by EmblemHealth Insurance Company. The above benefits and services do not require referrals by a Millennium 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 policy form number 151-23-NSGHDEPOSCH (04/20), 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.



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.