EmblemHealth®

SUMMARY OF BENEFITS

EmblemHealth Silver Value S

[PHSVS1005]

COST-SHARING	COMMENTS / LIMITATIONS	IN-NETWORK
Deductible Individual Family	Applies to hospital, medical and pharmacy	 $5,800 per plan year $11,600 per plan year
Prescription Drug Deductible		Generic drugs not subject to deductible
Out-of-Pocket Maximum Individual Family		 $5,800 per plan year $11,600 per plan year
OFFICE VISITS		
Primary Care Physician Office Visit	3 visits covered in full, not subject to deductible	After 3 visits, $35 copayment not subject to deductible
Specialist Care Physician Office Visit	PCP referral required	$55 copayment not subject to deductible
Telemedicine Physician Dietician		 $0 copayment not subject to deductible $0 copayment not subject to deductible
PREVENTIVE CARE SERVICES		
Well-Baby and Well-Child Care, including Immunizations*		Covered in full
Adult Annual Physical Checkup and Adult Immunizations*		Covered in full
Routine Gynecological Services/Well Woman Exams, Mammography Screenings*		Covered in full
Vasectomy		See surgical services below
All other preventive services*		Covered in full
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF or HRSA		See applicable service type
EMERGENCY CARE		
Emergency Room	Copayment waived if admitted to hospital	$0 copayment after deductible
Urgent Care Center		$75 copayment not subject to deductible
Ambulance		$0 copayment after deductible
PROFESSIONAL SERVICES and OUTPATIENT CARE		
Acupuncture	Preauthorization required	$20 copayment not subject to deductible
Advanced Imaging	Referral required	$0 Copayment after deductible
Allergy Care Performed in PCP Office Performed in Specialist Office	 PCP referral required	 $0 copayment after deductible $0 copayment after deductible
Ambulatory Surgical Facility	Preauthorization required	$0 copayment after deductible
Anesthesia Services (all settings)		Covered in full
Cardiac and Pulmonary Rehabilitation	Preauthorization required	$0 copayment after deductible
Chemotherapy (all settings)	Referral required to see specialist	$0 copayment after deductible
Chiropractic Services		$0 copayment after deductible
Diagnostic Testing Performed in PCP Office Performed in Specialist Office	 PCP referral required	 $35 copayment not subject to deductible $55 copayment not subject to deductible
Dialysis	Referral required to see specialist	$0 copayment after deductible
Habilitation and Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	Preauthorization 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	$0 copayment after deductible
Home Health Care	Preauthorization required. 40 visits per plan year	$0 copayment after deductible

Laboratory Procedures Performed in PCP Office Performed in Specialist Office		 $0 copayment not subject to deductible $0 copayment not subject to deductible
PROFESSIONAL SERVICES and OUTPATIENT CARE (con't)		
Maternity and Newborn Care Inpatient Hospital and Birthing Center Prenatal Care Postnatal Care	Preauthorization required for inpatient services	 $0 copayment after deductible Covered in full Covered in full
Preadmission Testing	Preauthorization required	$0 copayment not subject to deductible
Diagnostic Radiology Services Performed in PCP Office Performed in Specialist Office	 Preauthorization required	 $35 copayment not subject to deductible $55 copayment not subject to deductible
Second Opinions on the Diagnosis of Cancer, Surgery and Other	Referral required	$0 copayment after deductible
Surgical Services Surgical Services in In-Patient/Out-Patient Facility PCP Office Surgery Specialist Office Surgery	Preauthorization required	 $0 copayment after deductible $0 copayment after deductible $0 copayment after deductible
ADDITIONAL SERVICES, EQUIPMENT and DEVICES		
Diabetic Equipment, Supplies and Insulin	Preauthorization required	$35 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.	30% coinsurance not subject to deductible
External Hearing Aids	Preauthorization required. Single purchase, once every three years.	30% coinsurance not subject to deductible
Inpatient Hospice Care	Preauthorization required. 210 days per plan year	$0 copayment after deductible
INPATIENT SERVICES and FACILITIES		
Inpatient Hospital Service	Preauthorization required, except for emergency admissions	$0 copayment after deductible per admission
Skilled Nursing Facility Care	Preauthorization required. 200 days per plan year	$0 copayment after deductible per admission
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	Preauthorization required. 60 days per plan year, combined therapies. Speech and physical therapy are only covered following a hospital stay or surgery	$0 copayment after deductible per admission
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	Preauthorization required. 60 days per plan year, combined therapies	$0 copayment after deductible per admission
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Inpatient Mental Health Care	Preauthorization required, except for emergency admissions	$0 copayment after deductible per admission
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)		$35 copayment not subject to deductible
Inpatient Substance Use Services	Preauthorization required, except for Emergency Admissions or for Participating OASAS-certified Facilities	$0 copayment after deductible per admission
Outpatient Substance Use Services	Up to 20 visits per plan year may be used for family counseling.	$35 copayment not subject to deductible

PERSCRIPTION DRUGS

Retail Pharmacy Tier 1 Tier 2 Tier 3	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	 $10 copayment not subject to deductible $0 copayment after deductible $0 copayment after deductible
Mail Order Pharmacy Tier 1 Tier 2 Tier 3		 $25 copayment not subject to deductible $0 copayment after deductible $0 copayment after deductible
WELLNESS BENEFIT	COMMENTS/LIMITATIONS	IN-NETWORK
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
PEDIATRIC VISION CARE		
Exams	One exam per 12 month period. Coverage up to age 19 end of month.	$0 copayment not subject to deductible
Lenses and Frames	One set of lenses and frames or contacts per 12 month period. Coverage up to age 19 end of month	0% coinsurance not subject to deductible
Contact Lenses		0% coinsurance not subject to deductible
ADULT VISION CARE		
Exams	One exam per 12 month period	$0 copayment not subject to deductible
Lenses and Frames	One set of lenses and frames or contacts per 12 month period	0% coinsurance not subject to deductible
Contact Lenses		0% coinsurance not subject to deductible
PEDIATRIC DENTAL CARE		
Emergency Dental Care		$35 copayment not subject to deductible
Preventive Dental Care	One dental exam and cleaning per 6 month period	$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	$35 copayment not subject to deductible
Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery)	Requires preauthorization	$55 copayment not subject to deductible
Orthodontics	Requires preauthorization	$55 copayment not subject to deductible
ADULT DENTAL CARE		
Emergency Dental Care		$35 copayment not subject to deductible
Preventive Dental Care	One dental exam and cleaning per 6 month period	$0 copayment not subject to deductible
Routine Dental Care	Full mouth x-rays or panoramic x-rays at thirty-six 36 month intervals and bitewing x-rays at 6 month intervals	$35 copayment not subject to deductible

EmblemHealth Plans are underwritten by HIP Health Plan of New York. Except for emergency care, the above benefits and services are covered only when provided or referred by a Prime network primary care 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 HIP policy form number 155-23-NSSGOFFHIXSSchedule (04/17), 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 when a referral is obtained. Dialysis performed by non- participating providers is limited to 10 visits per calendar year. Preauthorization required.

EmblemHealth®

GETTING HELP IN A LANGUAGE OTHER THAN ENGLISH

ATTENTION: This is an important document. If you need help to understand it, please call the telephone number marked “customer service” on the back of your member ID card [TTY/TDD: 711]. We can give you an interpreter for free in the language you speak.

Español (Spanish)
ATENCIÓN: Este es un documento importante. Si necesita ayuda para entenderlo, llame al número telefónico marcado “customer service” que se encuentra en el dorso de su tarjeta de identificación de miembro [TTY/TDD: 711]. Le podemos proporcionar un intérprete que habla su idioma sin ningún costo.

中文 **(Traditional Chinese)**
注意：這是重要的文件。如果您需要協助來瞭解文件內容，請致電您會員卡背面標記為“customer service”的電話號碼[TTY/TDD：711]。我們可以為您免費提供您所使用語言的翻譯人員。

Русский (Russian)
ВНИМАНИЕ! Это важный документ. Если у Вас возникли трудности с пониманием этого документа и Вам необходима помощь, позвоните по телефону отдела обслуживания клиентов (customer service), указанному на обратной стороне Вашей идентификационной карточки [служба текстового телефона (TTY/TDD): 711]. Мы можем бесплатно предоставить Вам переводчика, который говорит на Вашем языке.

Kreyòl Ayisyen (Haitian Creole)
ATANSYON: Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo ki make “customer service” nan do kat ID manm ou [TTY/TDD: 711]. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

한국어 **(Korean)**
주의: 이것은 중요한 문서입니다. 이 문서를 이해하는 데 도움이 필요하시면 회원ID 카드의 뒷면에“customer service”라고 표시된 전화번호[TTY/TDD: 711]로 연락해 주십시오. 저희는 귀하가 사용하는 언어에 대해 무료 통역사를 제공할 수 있습니다.

Italiano (Italian)
ATTENZIONE. Questo è un documento importante. Per qualsiasi chiarimento telefoni all “customer service” al numero stampato sul retro della Sua tessera (per i non udenti: 711). Possiamo mettere a disposizione gratis un interprete nella Sua lingua.

(Yiddish) אידיש

מעלדונג: דאס איז א וויכטיגע דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט דעם טעלעפון נומבער גערופן “customer service” אויף אייער קארטל [TTY/TDD: 711]. מיר קענען אייך געבן אן איבערזעצער פריי אין די שפראך וואס איר רעדט.

বাংলা **(Bengali)**

দৃষ্টি আকর্ষণ করছি: এটি একটি গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয়, তাহলে অনুগ্রহ করে আপনার মেম্বার আইডি কার্ডের উল্টোপিঠে “customer service” চিহ্নিত টেলিফোন নম্বরে [TTY/TDD: 711] কল করুন। আপনি যে ভাষায় কথা

Polski (Polish)
UWAGA: To jest ważny dokument. Jeżeli potrzebujesz pomocy w celu zrozumienia jego treści, zadzwoń do „customer service” pod numer telefonu podany na odwrocie karty identyfikacyjnej ubezpieczonego (member ID card) [TTY/TDD: 711]. Możemy bezpłatnie zapewnić usługi tłumacza języka, którym się posługujesz.

(Arabic) العربية

انتباه: هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم المشار إليه بـ "customer service" على ظهر بطاقة عضويتك [TTY/TDD: 711]. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجاناً.

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Français (French)
ATTENTION : ce document est important. Si vous avez besoin d'aide pour en comprendre le contenu, veuillez composer le numéro «customer service » au dos de votre carte de membre [Sourds et malentendants : 711]. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

(Urdu) اردو

توجہ دیں: یہ ایک اہم دستاویزہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو برا ہ کرم "customer service" والے نمبر پر کال کریں جو آپ کے ممبر آئی ڈی کارڈ کی پشت پر درج ہے [ٹی ٹی وائی/ٹی ڈی ڈی: 711]۔آپ جو زبان بولتے ہیں اس میں ہم آپ کو مفت مترجم فراہم کرسکتے ہیں۔

Tagalog (Tagalog)
NANAWAGAN NG PANSIN: Ito ay isang mahalagang dokumento. Kung kailangan mo ng tulong para maintindihan ito, pakitawagan ang numero ng telepono na minarkahang "customer service" sa likod ng inyong ID card ng miyembro [TTY/TDD: 711]. Maaari ka naming bigyan ng libreng interpreter sa wikang iyong sinasalita.

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ: Αυτό το έγγραφο είναι σημαντικό. Εάν χρειάζεστε βοήθεια για να το κατανοήσετε, καλέστε μας στον αριθμό που σημειώνεται ως «customer service» στο πίσω μέρος της κάρτας της συνδρομής σας [αριθμός για άτομα με προβλήματα ακοής (TTY/TDD): 711]. Μπορούμε να σας προσφέρουμε δωρεάν διερμηνεία στη μητρική σας γλώσσα.

Shqip (Albanian)
VINI RE: Ky është një dokument i rëndësishëm. Nëse ju nevojitet ndihmë për ta kuptuar, ju lutemi telefononi në numrin ku shkruhet "customer service", i cili gjendet ne anen e pasme të kartës tuaj identifikuese të anëtarësisë [Shërbimi rele TTY/TDD: 711]. Ne mund t'ju ofrojmë pa pagesë një përkthyes në gjuhën që flisni ju.

NOTICE OF NONDISCRIMINATION POLICY

EmblemHealth complies with applicable 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 communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the telephone number marked "customer service" on the back of your member ID card. 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 the telephone number marked "customer service" on the back of your member ID card. (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**.