SUMMARY OF BENEFITS

EmblemHealth Platinum

PHPLTA011 / MH001046

Select Care - Referral Required

COST-SHARING	COMMENTS / LIMITATIONS	IN-NETWORK
Deductible Individual Family	Applies to hospital, medical, dental, vision and pharmacy	 $0 per plan year $0 per plan year
Out-of-Pocket Maximum Individual Family		 $2,000 per plan year $4,000 per plan year
OFFICE VISITS		
Primary Care Physician Office Visit		$15 copayment
Specialist Care Physician Office Visit	PCP referral required	$35 copayment
Telemedicine Physician		 Covered in full
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	$100 copayment
Urgent Care Center		$55 copayment
Ambulance		$100 copayment
PROFESSIONAL SERVICES and OUTPATIENT CARE		
Advanced Imaging	Preauthorization required	$35 copayment
Allergy Care Performed in PCP Office Performed in Specialist Office	 Referral required	 $15 copayment $35 copayment
Ambulatory Surgical Facility	Preauthorization required	$100 copayment
Anesthesia Services (all settings)		Covered in full
Cardiac and Pulmonary Rehabilitation	Preauthorization required	$15 copayment
Chemotherapy (all settings)	Preauthorization required	$15 copayment
Chiropractic Services		$35 copayment
Diagnostic Testing Performed in PCP Office Performed in Specialist Office	Referral required to see a specialist. Preauthorization required for Outpatient services.	 $15 copayment $35 copayment
Dialysis	Referral required to see specialist	$15 copayment
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	$25 copayment
Home Health Care	Preauthorization required. 40 visits per plan year	$15 copayment

PROFESSIONAL SERVICES and OUTPATIENT CARE (con't)		
Laboratory Procedures Performed in PCP Office Performed in Specialist Office	Preauthorization required for Outpatient services.	 $15 copayment $35 copayment
Maternity and Newborn Care Inpatient Hospital and Birthing Center Prenatal Care	Preauthorization required for Inpatient services	 $500 copayment Covered in full
Preadmission Testing	Preauthorization required	$0 copayment
Diagnostic Radiology Services Performed in PCP Office Performed in Specialist Office	Preauthorization required	 $15 copayment $35 copayment
Second Opinions on the Diagnosis of Cancer, Surgery and Other	Referral required	$35 copayment
Surgical Services Surgical Services in In-Patient/Out-Patient Facility PCP Office Surgery Specialist Office Surgery	Preauthorization required	 $100 copayment $15 copayment $35 copayment
ADDITIONAL SERVICES, EQUIPMENT and DEVICES		
Diabetic Equipment, Supplies and Insulin	Preauthorization required	$15 copayment, with $100 max, 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.	10% coinsurance
External Hearing Aids	Preauthorization required. Single purchase, once every three years.	10% coinsurance
Inpatient Hospice Care	Preauthorization required. 210 days per plan year	$500 copayment
INPATIENT SERVICES and FACILITIES		
Inpatient Hospital Service	Preauthorization required, except for emergency admissions	$500 copayment, per admission
Skilled Nursing Facility Care	Preauthorization required. 200 days per plan year	$500 copayment, 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	$500 copayment, per admission
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	Preauthorization required. 60 days per plan year, combined therapies	$500 copayment, per admission
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Inpatient Mental Health Care	Preauthorization required, except for emergency admissions or for admission at Participating OHM-licensed Facilities for Members under 18.	$500 copayment, per admission
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)		$15 copayment
Inpatient Substance Use Services	Preauthorization required, except for Emergency Admissions or for Participating OASAS-certified Facilities	$500 copayment, per admission
Outpatient Substance Use Services	Up to 20 visits per plan year may be used for family counseling.	$15 copayment

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.	 $10 copayment $30 copayment $60 copayment
Mail Order Pharmacy Tier 1 Tier 2 Tier 3		 $25 copayment $75 copayment $150 copayment
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-- Pediatric coverage up to age 19 end of month		
Exams	One exam per 12-month period.	$15 copayment
Frames	One set of provider designated frames per 12-month period.	10% coinsurance*
Standard Plastic Lenses Single Vision Bifocal Trifocal Lenticular Standard Progressive Lens	One set of lenses or provider designated contacts per 12-month period.	10% coinsurance*
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	10% coinsurance*
PEDIATRIC DENTAL CARE		
Preventive Dental Care	One dental exam and cleaning per 6-month period	$15 copayment
Routine Dental Care	Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at 6-month intervals	$15 copayment
Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery)	Requires preauthorization	$15 copayment
Orthodontics	Requires preauthorization	$15 copayment

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 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-IONHIXPSchedule (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 when a referral is obtained. Dialysis performed by non- participating providers is limited to 10 visits per calendar year. Preauthorization required.

* 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**.