EmblemHealth Platinum Premier
Summary of Benefits
Select Care Network - No Referral Required

PPPLTS002 / MS001002

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Plan Deductible	$100 $200	$4,000 $8,000
Separate Prescription Drug Deductible	$100 $200	Not Applicable Not Applicable
Out-of-Pocket Maximum	$2,300 $4,600	$10,000 $20,000
Benefits	**In-Network (INET) Member Pays**	**Out-of-network (OON) Member Pays**
Provider Office Visits		
Mental Health and Substance Abuse Office Visits First 3 In-Network visits (any combination of PCP, ABA, MH/SUD), covered in full.	Thereafter, Office Visits: $10 copayment not subject to deductible All Other Outpatient Services: $10 copayment not subject to deductible	50% coinsurance after deductible
ABA Treatment for Autism Spectrum Disorder First 3 In-Network visits (any combination of PCP, ABA, MH/SUD), covered in full. Preauthorization required.	Thereafter, $10 copayment not subject to deductible	50% coinsurance after deductible
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations) First 3 In-Network visits (any combination of PCP, ABA, MH/SUD), covered in full.	Thereafter, $10 copayment not subject to deductible	50% coinsurance after deductible
Specialist Office Visits	$35 copayment not subject to deductible	50% coinsurance after deductible
Telemedicine Services	No Charge	Not Covered
Preventive Office Visits		
Adult/Pediatric Preventive Visits	No Charge	50% coinsurance after deductible
Prenatal Care	No Charge	50% coinsurance after deductible

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

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Routine Gynecological Services/Well Woman Exams, Mammography Screenings*	No Charge	50% coinsurance after deductible
Well-Baby and Well-Child Care, including Immunizations*	No Charge	50% coinsurance after deductible
***When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF or HRSA**	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)
Vasectomy	See surgical services	See surgical services
All Other Preventive Services*	No Charge	50% coinsurance after deductible
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI) Preauthorization required.	Performed in a Freestanding Facility or Specialist Office: $35 copayment after deductible Performed in an Outpatient Facility: $75 copayment after deductible	50% coinsurance after deductible
Laboratory Services Preauthorization required.	Performed in a Freestanding Facility or PCP Office: $10 copayment not subject to deductible Performed in a Specialist Office: $35 copayment not subject to deductible Performed in an Outpatient Facility: $125 copayment not subject to deductible	50% coinsurance after deductible
Non-Advanced Radiology (X-ray, Diagnostic) Preauthorization may be required.	Performed in a Freestanding Facility or PCP Office: $10 copayment after deductible Performed in a Specialist Office: $35 copayment after deductible Performed in an Outpatient Facility: $125 copayment after deductible	50% coinsurance after deductible
Preadmission Testing Preauthorization required.	$0 copayment after deductible	50% coinsurance after deductible
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$35 copayment after deductible	50% coinsurance after deductible

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Prescription Drugs – Retail Pharmacy (cost-share based on 30-day supply per prescription) 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.		
Preferred Generic Tier 1	$5 copayment not subject to deductible	Not Covered
Non-preferred Generic Tier 2	$30 copayment after deductible	Not Covered
Preferred Brand Tier 3	$65 copayment after deductible	Not Covered
Prescription – Mail Order Pharmacy (up to a 90-day supply per prescription)		
Preferred Generic Tier 1	$12.50 copayment not subject to deductible	Not Covered
Non-preferred Generic Tier 2	$75 copayment after deductible	Not Covered
Preferred Brand Tier 3	$162.50 copayment after deductible	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Physical and Occupational Therapy 60 visits per condition/plan year, combined therapies.	Performed in a PCP Office: $10 copayment after deductible Performed in a Specialist Office: $35 copayment after deductible	Not Covered
Other Services		
Anesthesia Services	No Charge	50% coinsurance after deductible
Cardiac and Pulmonary Rehabilitation Preauthorization required for Inpatient services.	$50 copayment after deductible	50% coinsurance after deductible
Chemotherapy	Performed in a PCP Office: $10 copayment after deductible Performed in a Specialist Office: $35 copayment after deductible Performed in an Outpatient Facility: $75 copayment after deductible	50% coinsurance after deductible
Chiropractic Services	$35 copayment not subject to deductible	50% coinsurance after deductible
Diabetic Equipment and Supplies 90-day supply mail order available In-Network. Preauthorization may be required.	$10 copayment not subject to deductible per 30-day supply	50% coinsurance after deductible

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Dialysis Preauthorization may be required.	Performed in a PCP Office: $10 copayment after deductible Performed in a Specialist Office: $35 copayment after deductible	50% coinsurance after deductible
Durable Medical Equipment (DME)	10% coinsurance after deductible	Not Covered
External Hearing Aids Single purchase once every 3 years. Preauthorization required.	10% coinsurance after deductible	Not Covered
Home Health Care 40 visits per plan year. Preauthorization required.	$35 copayment after deductible	50% coinsurance after deductible
Outpatient Services (in a hospital or ambulatory facility) Preauthorization may be required.	$250 copayment after deductible	50% coinsurance after deductible
Inpatient Services		
Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility and all IP settings Preauthorization required, except for emergency admissions.	20% coinsurance after deductible, per admission	50% coinsurance after deductible (Hospice and Skilled Nursing not covered)
Inpatient Rehabilitation Services 60 days per condition/plan year, combined therapies. Preauthorization required.	20% coinsurance after deductible, per admission	Not Covered
Inpatient Habilitation Services 60 days per condition/plan year, combined therapies. Preauthorization required.	20% coinsurance after deductible, per admission	Not Covered
Emergency and Urgent Care		
Ambulance Services	$250 copayment after deductible	$250 copayment after deductible
Emergency Room Waived if admitted to Hospital.	20% coinsurance after deductible	20% coinsurance after deductible
Urgent Care Centers	$100 copayment after deductible	50% coinsurance after deductible
Pediatric Dental Care - up to age 19 end of month		
Preventive Dental Care 1 dental exam and cleaning per 6- month period.	No Charge	Not Covered

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Routine Dental Care Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at 6-month intervals.	$10 copayment not subject to deductible	Not Covered
Major Dental Care Preauthorization required.	$35 copayment after deductible	Not Covered
Orthodontia Preauthorization required.	$35 copayment after deductible	Not Covered
Pediatric Vision Care - up to age 19 end of month		
Contact Lens 1 set of prescribed lenses and frames per 12-month period.	10% coinsurance not subject to deductible	Not Covered
Prescription Eye Glasses 1 set of prescribed lenses and frames per 12-month period.	10% coinsurance not subject to deductible	Not Covered
Routine Eye Exam 1 exam per 12-month period.	No Charge	Not Covered
Additional Covered Services		
Allergy Testing	Performed in a PCP Office: $10 copayment after deductible Performed in a Specialist Office: $35 copayment after deductible	50% coinsurance after deductible
Gym Reimbursement Gym reimbursement benefit does not apply towards the deductible or out-of-pocket maximum	$200 per 6-month calendar year period; $100 per 6-month calendar year period for covered dependent(s)	$200 per 6-month calendar year period; $100 per 6-month calendar year period for covered dependent(s)
Important information		

EmblemHealth plans are underwritten by Health Insurance Plan of Greater New York (HIP). The above benefits and services do not require referrals by a Select Care Network primary care physician.

Preauthorization will still be required for noted benefits. If you do not get Preauthorization for Out-of-Network services subject to this requirement, we will reduce your benefit by $500 or 50%, whichever is less to you. 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 155-OA-NSSGPlatinumPremierSch (4/23), et al.

Certain services must be approved in advance by EmblemHealth.

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**).

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**.