EmblemHealth

SUMMARY OF BENEFITS

EmblemHealth Gold Open Access

[PHGLDC001]

COST-SHARING	COMMENTS / LIMITATIONS	IN-NETWORK
Deductible Individual Family	Applies to hospital, medical and pharmacy	 $700 per plan year $1,400 per plan year
Prescription Drug Deductible Individual Family	Generic drugs not subject to deductible	 $100 per plan year $200 per plan year
Out-of-Pocket Maximum Individual Family		 $5,000 per plan year $10,000 per plan year
OFFICE VISITS		
Primary Care Physician Office Visit	3 visits covered in full, not subject to deductible	After 3 visits, $10 copayment not subject to deductible
Specialist Care Physician Office Visit		$50 copayment after 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	$150 copayment after deductible
Urgent Care Center		$50 copayment not subject to deductible
Ambulance		$150 copayment after deductible
PROFESSIONAL SERVICES and OUTPATIENT CARE		
Acupuncture		$20 copayment not subject to deductible
Advanced Imaging		$50 copayment after deductible
Allergy Care Performed in PCP Office Performed in Specialist Office		 $10 copayment after deductible $50 copayment after deductible
Ambulatory Surgical Facility		$0 copayment after deductible
Anesthesia Services (all settings)		Covered in full
Cardiac and Pulmonary Rehabilitation Performed in Specialist Office Performed as Outpatient Hospital Services		 $50 copayment after deductible $50 copayment after deductible
Chemotherapy Performed in PCP Office Performed in Specialist Office		 $10 copayment after deductible $50 copayment after deductible
Chiropractic Services		$50 copayment after deductible
Diagnostic Testing Performed in PCP Office Performed in Specialist Office		 $10 copayment not subject to deductible $50 copayment not subject to deductible
Dialysis Performed in PCP Office Performed in Specialist Office		 $10 copayment after deductible $50 copayment after deductible

Habilitation and Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	Combined 90 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	$50 copayment after deductible
Home Health Care	40 visits per plan year	$50 copayment after deductible
Laboratory Procedures (all settings)		$10 copayment after deductible
PROFESSIONAL SERVICES and OUTPATIENT CARE (con't)		
Maternity and Newborn Care Inpatient Hospital and Birthing Center Prenatal Care Postnatal Care		 $1,500 copayment after deductible Covered in full Covered in full
Preadmission Testing		$0 copayment not subject to deductible
Diagnostic Radiology Services Performed in PCP Office Performed in Specialist Office		 $10 copayment not subject to deductible $50 copayment not subject to deductible
Second Opinions on the Diagnosis of Cancer, Surgery and Other		$50 copayment after deductible
Surgical Services Surgical Services in In-Patient/Out-Patient Facility PCP Office Surgery Specialist Office Surgery		 $150 copayment after deductible $10 copayment after deductible $50 copayment after deductible
ADDITIONAL SERVICES, EQUIPMENT and DEVICES		
Diabetic Equipment, Supplies and Insulin		$10 copayment after deductible, per 30 day supply
Durable Medical Equipment	One external prosthetic device per limb per lifetime with coverage for repairs and replacement. No orthotics.	10% coinsurance after deductible
External Hearing Aids	Single purchase, once every three years.	10% coinsurance after deductible
Inpatient Hospice Care	210 days per plan year	$1,500 copayment after deductible
INPATIENT SERVICES and FACILITIES		
Inpatient Hospital Service		$1,500 copayment after deductible per admission
Skilled Nursing Facility Care	200 days per plan year	$1500 copayment after deductible per admission
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	60 days per plan year, combined therapies. Speech and physical therapy are only covered following a hospital stay or surgery	$1,500 copayment after deductible per admission
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	60 days per plan year, combined therapies	$1,500 copayment after deductible per admission
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Inpatient Mental Health Care		$1,500 copayment after deductible per admission
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)		$10 copayment after deductible
Inpatient Substance Use Services		$1,500 copayment after deductible per admission
Outpatient Substance Use Services	Up to 20 visits per plan year may be used for family counseling.	$10 copayment after 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 $30 copayment after deductible $70 copayment after deductible
Mail Order Pharmacy Tier 1 Tier 2 Tier 3		$25 copayment not subject to deductible $75 copayment after deductible $175 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.	$10 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	10% coinsurance not subject to deductible
Contact Lenses		10% coinsurance not subject to deductible
ADULT VISION CARE		
Exams	One exam per 12 month period	$10 copayment not subject to deductible
Lenses and Frames	One set of lenses and frames or contacts per 12 month period	10% coinsurance not subject to deductible
Contact Lenses		10% coinsurance not subject to deductible
PEDIATRIC DENTAL CARE		
Emergency Dental Care		$10 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	$10 copayment not subject to deductible
Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery)		$50 copayment not subject to deductible
Orthodontics		$50 copayment not subject to deductible
ADULT DENTAL CARE		
Emergency Dental Care		$10 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	$10 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-OA-SGOFFHIXCERT(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.