



SUMMARY OF BENEFITS

EmblemHealth Silver Premier-M

Millennium - Referral Required

PHSIRM003 / MH001191

| COST-SHARING | COMMENTS / LIMITATIONS | IN-NETWORK |
|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| Deductible Individual Family | Applies to hospital, medical, dental, and vision | \$3,800 per plan year \$7,600 per plan year |
| Prescription Drug Deductible | | \$0 per plan year |
| Out-of-Pocket Maximum Individual Family | | \$8,000 per plan year \$16,000 per plan year |
| OFFICE VISITS | | |
| Primary Care Physician Office Visit | 3 visits covered in full ^ | \$35 copayment not subject to deductible |
| Specialist Care Physician Office Visit | PCP referral required | \$65 copayment not subject to deductible |
| 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 | 40% coinsurance after deductible |
| Urgent Care Center | | \$75 copayment not subject to deductible |
| Ambulance | | \$350 copayment after deductible |
| PROFESSIONAL SERVICES and OUTPATIENT CARE | | |
| Advanced Imaging | Preauthorization required for Outpatient services | \$65 copayment after deductible |
| Allergy Care Performed in PCP Office Performed in Specialist Office | Referral required | \$35 copayment after deductible \$65 copayment after deductible |
| Ambulatory Surgical Facility | Preauthorization required | \$350 copayment after deductible |
| Anesthesia Services (all settings) | | Covered in full |
| Cardiac and Pulmonary Rehabilitation | Preauthorization required | \$65 copayment after deductible |
| Chemotherapy Performed in PCP Office Performed in Specialist Office | Referral required to see specialist Preauthorization required | \$35 copayment after deductible \$65 copayment after deductible |
| Chiropractic Services | | \$65 copayment not subject to deductible |
| Diagnostic Testing Performed in PCP Office Performed in Specialist Office | Referral required to see specialist. Preauthorization required for Outpatient services | \$35 copayment after deductible \$65 copayment after deductible |
| Dialysis Performed in PCP Office Performed in Specialist Office | Referral required to see specialist | \$35 copayment after deductible \$65 copayment after deductible |
| Habilitation and Rehabilitation Services (Physical, Occupational or Speech Therapy) Performed in PCP Office Performed in Specialist Office | Preauthorization Required. Combined 60 visits/condition/plan year Occupational, Physical and Speech. Unlimited visits/year Cardiac and Respiratory | \$35 copayment after deductible \$65 copayment after deductible |
| Home Health Care | Preauthorization required. 40 visits per plan year | \$65 copayment after deductible |

| PROFESSIONAL SERVICES and OUTPATIENT CARE (con't) | | |
|------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| Laboratory Procedures Performed in PCP Office Performed in Specialist Office | Preauthorization required for Outpatient services | \$35 copayment not subject to deductible \$65 copayment not subject to deductible |
| Maternity and Newborn Care Inpatient Hospital and Birthing Center Prenatal Care | Preauthorization required for Inpatient services | 40% coinsurance after deductible 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 after deductible \$65 copayment after deductible |
| Second Opinions on the Diagnosis of Cancer, Surgery and Other | Referral required | \$65 copayment after deductible |
| Surgical Services Surgical Services in In-Patient/Out-Patient Facility PCP Office Surgery Specialist Office Surgery | Preauthorization required | \$350 copayment after deductible \$35 copayment after deductible \$65 copayment after deductible |
| ADDITIONAL SERVICES, EQUIPMENT and DEVICES | | |
| Diabetic Equipment, Supplies and Insulin | Preauthorization required | \$35 copayment not subject to deductible, 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. | 30% coinsurance after deductible |
| External Hearing Aids | Preauthorization required. Single purchase, once every three years. | 30% coinsurance after deductible |
| Inpatient Hospice Care | Preauthorization required. 210 days per plan year | 40% coinsurance after deductible |
| INPATIENT SERVICES and FACILITIES | | |
| Inpatient Hospital Service | Preauthorization required, except for emergency admissions | 40% coinsurance after deductible, per admission |
| Skilled Nursing Facility Care | Preauthorization required. 200 days per plan year | 40% coinsurance after deductible, per admission |
| Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) | Preauthorization required. 60 days per plan year, combined therapies. | 40% coinsurance after deductible, per admission |
| Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) | Preauthorization required. 60 days per plan year, combined therapies | 40% coinsurance after deductible, 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. | 40% coinsurance after deductible, per admission |
| Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) | 3 free visits, covered in full | \$35 copayment not subject to deductible |
| Inpatient Substance Use Services | Preauthorization required, except for Emergency Admissions or for Participating OASAS-certified Facilities | 40% coinsurance after deductible, per admission |
| Outpatient Substance Use Services | 3 free visits, covered in full Up to 20 visits per plan year may be used for family counseling. | \$35 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 |
| Mail Order Pharmacy Tier 1 Tier 2 Tier 3 | | \$0 copayment \$100 copayment \$200 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. | \$0 copayment not subject to deductible |
| Frames | One set of provider designated frames per 12-month period. | 30% 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. | 30% 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 | 30% coinsurance not subject to deductible * |
| PEDIATRIC DENTAL CARE -- Pediatric coverage up to age 19 end of month | | |
| Preventive Dental Care | One dental exam and cleaning per 6-month period | \$0 copayment not subject to deductible |
| Emergency Dental Care | | \$35 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 | \$65 copayment after deductible |
| Orthodontics | Requires preauthorization | \$65 copayment after deductible |

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 Millennium 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-NSSGSilverPremierMSch (04/21), 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.

^ Any combination of PCP, ABA, Mental Health, and Substance Use Disorder



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 (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**).

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)

NANANA VAGAI 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.