**SUMMARY OF BENEFITS**

**EmblemHealth Bronze D**

*Select Care - Referral Required [PHBRZB011] / [MH001117]*

<table>
<thead>
<tr>
<th>COST-SHARING</th>
<th>COMMENTS / LIMITATIONS</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Applies to hospital, medical, dental, vision and pharmacy</td>
<td>$4,425 per plan/year $8,850 per plan year</td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td></td>
<td>$8,150 per plan year $16,300 per plan year</td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OFFICE VISITS**

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician Office Visit</td>
<td>3 visits covered in full</td>
</tr>
<tr>
<td>Specialist Care Physician Office Visit</td>
<td>PCP referral required</td>
</tr>
<tr>
<td>Telemedicine Physicin</td>
<td></td>
</tr>
</tbody>
</table>

**PREVENTIVE CARE SERVICES**

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-Baby and Well-Child Care, including Immunizations*</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Adult Annual Physical Checkup and Adult Immunizations*</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Routine Gynecological Services/Well Woman Exams, Mammography Screenings*</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Vasectomy</td>
<td></td>
</tr>
<tr>
<td>All other preventive services*</td>
<td>See surgical services below</td>
</tr>
</tbody>
</table>

*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF or HRSA See applicable service type

**EMERGENCY CARE**

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td>Copayment waived if admitted to hospital</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td></td>
</tr>
</tbody>
</table>

**PROFESSIONAL SERVICES and OUTPATIENT CARE**

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Imaging</td>
<td>Preauthorization required</td>
</tr>
<tr>
<td>Allergy Care</td>
<td>Referral required</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility</td>
<td>Preauthorization required</td>
</tr>
<tr>
<td>Anesthesia Services (all settings)</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>Cardiac and Pulmonary Rehabilitation</td>
<td>Preauthorization required</td>
</tr>
<tr>
<td>Chemotherapy (all settings)</td>
<td>Preauthorization required</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>Referral required to see a specialist. Preauthorization required for Outpatient services.</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Referral required to see specialist</td>
</tr>
<tr>
<td>Habilitation and Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</td>
<td>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</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Preauthorization required. 40 visits per plan year</td>
</tr>
</tbody>
</table>

Group Health Incorporated (GHI), Health Insurance Plan of Greater New York (HIP), HIP Insurance Company of New York (HIPIC), and EmblemHealth Services Company LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.
| PROFESSIONAL SERVICES and OUTPATIENT CARE (con’t) |  |
|---|---|---|
| Laboratory Procedures | Preauthorization required for Outpatient services. | 50% coinsurance after deductible |
| Maternity and Newborn Care | Preauthorization required for Inpatient services | 50% coinsurance after deductible Covered in full |
| Inpatient Hospital and Birthing Center | Preauthorization required | 50% coinsurance after deductible |
| Prenatal Care | | |
| Preadmission Testing | Preauthorization required | 50% coinsurance after deductible |
| Diagnostic Radiology Services | Preauthorization required | 50% coinsurance after deductible |
| Second Opinions on the Diagnosis of Cancer, Surgery and Other | Referral required | 50% coinsurance after deductible |
| Surgical Services | Preauthorization required | 50% coinsurance after deductible |
| Surgical Services in In-Patient/Out-Patient Facility | | 50% coinsurance after deductible |
| PCP Office Surgery | | 50% coinsurance after deductible |
| Specialist Office Surgery | | 50% coinsurance after deductible |

| ADDITIONAL SERVICES, EQUIPMENT and DEVICES |  |
|---|---|---|
| Diabetic Equipment, Supplies and Insulin | Preauthorization required | 50% coinsurance after 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. | 50% coinsurance after deductible |
| External Hearing Aids | Preauthorization required. Single purchase, once every three years. | 50% coinsurance after deductible |
| Inpatient Hospice Care | Preauthorization required. 210 days per plan year | 50% coinsurance after deductible |

| INPATIENT SERVICES and FACILITIES |  |
|---|---|---|
| Inpatient Hospital Service | Preauthorization required, except for emergency admissions | 50% coinsurance after deductible |
| Skilled Nursing Facility Care | Preauthorization required. 200 days per plan year | 50% coinsurance after deductible |
| 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 | 50% coinsurance after deductible |
| Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) | Preauthorization required. 60 days per plan year, combined therapies | 50% coinsurance after deductible |

| MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES |  |
|---|---|---|
| Inpatient Mental Health Care | Preauthorization required, except for emergency admissions or for admission at Participating OBM-licensed Facilities for Members under 18. | 50% coinsurance after deductible |
| Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) | | 50% coinsurance after deductible |
| Inpatient Substance Use Services | Preauthorization required, except for Emergency Admissions or for Participating OASAS-certified Facilities | 50% coinsurance after deductible |
| Outpatient Substance Use Services | Up to 20 visits per plan year may be used for family counseling. | 50% coinsurance after deductible |

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PERSCRIPTION DRUGS

<table>
<thead>
<tr>
<th>Tier</th>
<th>Retail Pharmacy</th>
<th>Mail Order Pharmacy</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
<td>$25 copayment after deductible</td>
<td>$87.50 copayment after deductible</td>
<td>$175 copayment after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$10 copayment after deductible</td>
<td>$35 copayment after deductible</td>
<td>$70 copayment after deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WELLNESS BENEFIT

<table>
<thead>
<tr>
<th>Gym Reimbursement</th>
<th>COMMENTS/LIMITATIONS</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gym reimbursement benefit does not apply towards the deductible or out of pocket maximum</td>
<td>Subscriber reimbursed up to $200 for completion of 50 exercise facility visits in each six-month period</td>
</tr>
</tbody>
</table>

PEDIATRIC VISION CARE-- Pediatric coverage up to age 19 end of month

<table>
<thead>
<tr>
<th>Exams</th>
<th>Frames</th>
<th>Standard Plastic Lenses</th>
<th>Contact Lenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>One exam per 12-month period.</td>
<td>One set of provider designated frames per 12-month period.</td>
<td>One set of lenses or provider designated contacts per 12-month period.</td>
<td>One pair from selection of provider designated contacts</td>
</tr>
<tr>
<td>50% coinsurance after deductible*</td>
<td>50% coinsurance after deductible*</td>
<td>50% coinsurance after deductible*</td>
<td>50% coinsurance after deductible*</td>
</tr>
</tbody>
</table>

PEDIATRIC DENTAL CARE

<table>
<thead>
<tr>
<th>Preventive Dental Care</th>
<th>Routine Dental Care</th>
<th>Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery)</th>
<th>Orthodontics</th>
</tr>
</thead>
<tbody>
<tr>
<td>One dental exam and cleaning per 6-month period</td>
<td>Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at 6-month intervals</td>
<td>Requires preauthorization</td>
<td>Requires preauthorization</td>
</tr>
<tr>
<td>50% coinsurance after deductible</td>
<td>50% coinsurance after deductible</td>
<td>50% coinsurance after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
</tbody>
</table>

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-I0FFHIXBSchedule (04/19), 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.

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Español (Spanish)

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)

Kreyòl Ayisyen (Haitian Creole)

한국어 (Korean)

Italiano (Italian)

Yiddish (Yiddish)

Bengali (Bengali)
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Polski (Polish)

Arabic (Arabic)
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**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).**

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Complaint forms are available at [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html).