



# SUMMARY OF BENEFITS

## EmblemHealth Gold Choice No Referral Required

[PHSGC1001] / [MH001037]

| COST-SHARING   | COMMENTS / LIMITATIONS                              | IN-NETWORK   |
|--|---|--|
| Deductible<br>Individual<br>Family   | Applies to hospital, medical, dental, vision & Rx   | \$750 per plan year<br>\$1,500 per plan year                       |
| Prescription Drug Deductible   |   |  |
| Out-of-Pocket Maximum<br>Individual<br>Family  |   | \$5,000 per plan year<br>\$10,000 per plan year                    |
| OFFICE VISITS  |   |  |
| Primary Care Physician Office Visit  | 3 visits covered in full, not subject to deductible | After 3 visits, \$30 copayment not subject to deductible           |
| Specialist Care Physician Office Visit   |   | \$50 copayment, not subject to deductible                          |
| Telemedicine<br>Physician  |   | \$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            | \$300 copayment after deductible                                   |
| Urgent Care Center   |   | \$75 copayment not subject to deductible                           |
| Ambulance  |   | \$150 copayment after deductible                                   |
| PROFESSIONAL SERVICES and OUTPATIENT CARE  |   |  |
| Acupuncture  |   | \$0 copayment not subject to deductible                            |
| Advanced Imaging   |   | \$50 copayment after deductible                                    |
| Allergy Care<br>Performed in PCP Office<br>Performed in Specialist Office  |   | \$30 copayment after deductible<br>\$50 copayment after deductible |
| Ambulatory Surgical Facility   |   | \$150 copayment after deductible                                   |
| Anesthesia Services (all settings)   |   | Covered in full  |
| Cardiac and Pulmonary Rehabilitation<br>Performed in Specialist Office<br>Performed as Outpatient Hospital Services    |   | \$50 copayment after deductible<br>\$50 copayment after deductible |
| Chemotherapy<br>Performed in PCP Office<br>Performed in Specialist Office  |   | \$30 copayment after deductible<br>\$50 copayment after deductible |
| Chiropractic Services  |   | \$50 copayment not subject to deductible                           |
| Diagnostic Testing<br>Performed in PCP Office<br>Performed in Specialist Office  |   | \$30 copayment after deductible<br>\$50 copayment after deductible |
| Dialysis<br>Performed in PCP Office<br>Performed in Specialist Office  |   | \$30 copayment after deductible<br>\$50 copayment after deductible |

|  |   |  |
|--|---|--|
| Habilitation and Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)                          | Combined 90 visits/condition/plan year<br>Occupational, Physical and Speech.<br>Speech and physical therapy for rehabilitation are only covered following a hospital stay or surgery<br>Unlimited visits/year Cardiac and Respiratory | \$50 copayment after deductible  |
| Home Health Care   | 40 visits per plan year   | \$50 copayment after deductible  |
| Laboratory Procedures<br>Performed in PCP Office<br>Performed in Specialist Office   |   | \$30 copayment not subject to deductible<br>\$50 copayment not subject to deductible                   |
| <b>PROFESSIONAL SERVICES and OUTPATIENT CARE (con't)</b>   |   |  |
| Maternity and Newborn Care<br>Inpatient Hospital and Birthing Center<br>Prenatal Care<br>Postnatal Care                      |   | \$2,000 copayment after deductible<br>Covered in full<br>Covered in full                               |
| Preadmission Testing   |   | \$0 copayment not subject to deductible  |
| Diagnostic Radiology Services<br>Performed in PCP Office<br>Performed in Specialist Office                                   |   | \$30 copayment after deductible<br>\$50 copayment after deductible                                     |
| Second Opinions on the Diagnosis of Cancer, Surgery and Other  |   | \$50 copayment after deductible  |
| Surgical Services<br>Surgical Services in In-Patient/Out-Patient Facility<br>PCP Office Surgery<br>Specialist Office Surgery |   | \$150 copayment after deductible<br>\$30 copayment after deductible<br>\$50 copayment after deductible |
| <b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>  |   |  |
| Diabetic Equipment, Supplies and Insulin   |   | \$30 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.   | 20% coinsurance after deductible   |
| External Hearing Aids  | Single purchase, once every three years.  | 20% coinsurance after deductible   |
| Inpatient Hospice Care   | 210 days per plan year  | \$2,000 copayment after deductible   |
| <b>INPATIENT SERVICES and FACILITIES</b>   |   |  |
| Inpatient Hospital Service   |   | \$2,000 copayment after deductible per admission   |
| Skilled Nursing Facility Care  | 200 days per plan year  | \$2,000 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  | \$2,000 copayment after deductible per admission   |
| Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)  | 60 days per plan year, combined therapies   | \$2,000 copayment after deductible per admission   |
| <b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER SERVICES</b>   |   |  |
| Inpatient Mental Health Care   |   | \$2,000 copayment after deductible per admission   |
| Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)                  |   | \$30 copayment not subject to deductible   |
| Inpatient Substance Use Services   |   | \$2,000 copayment after deductible per admission   |
| Outpatient Substance Use Services  | Up to 20 visits per plan year may be used for family counseling.  | \$30 copayment not subject to deductible   |

Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

| PERSCRIPTION DRUGS  |   |  |
|---|---|--|
| Retail Pharmacy<br>Tier 1<br>Tier 2<br>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 | \$20 copayment not subject to deductible<br>\$45 copayment after deductible<br>\$75 copayment after deductible   |
| Mail Order Pharmacy<br>Tier 1<br>Tier 2<br>Tier 3                                 |   | \$50 copayment not subject to deductible<br>\$113 copayment after deductible<br>\$188 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<br><br>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.   | \$0 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  | 20% coinsurance not subject to deductible  |
| Contact Lenses  |   | 20% coinsurance not subject to deductible  |
| ADULT VISION CARE   |   |  |
| Exams   | One exam per 12 month period  | \$0 copayment not subject to deductible  |
| Lenses and Frames   | One set of lenses and frames or contacts per 12 month period  | 20% coinsurance not subject to deductible  |
| Contact Lenses  |   | 20% coinsurance not subject to deductible  |
| PEDIATRIC DENTAL CARE   |   |  |
| Emergency Dental Care   |   | \$30 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  | \$30 copayment not subject to deductible   |
| Major Dental Care<br>(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   |   | \$30 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   | \$30 copayment not subject to deductible   |

EmblemHealth Plans are underwritten by HIP Health Plan of New York.

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-NSSGGoldChoiceSch (04/18), 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; no referral required.

Dialysis performed by non-participating providers is limited to 10 visits per calendar year.

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**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 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**).

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](https://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](https://hhs.gov/ocr/office/file/index.html).