EmblemHealth Select Care Bronze D
Summary of Benefits
Select Care Network - Referral Required

PHBRZB015 / MH001287

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays
Plan Deductible	$4,600 $9,200
Separate Prescription Drug Deductible	None
Out-of-Pocket Maximum	$9,450 $18,900
Benefits	**In-Network (INET) Member Pays**
Provider Office Visits	
Mental Health and Substance Abuse Office Visits First 3 visits (any combination of PCP, Specialist, ABA, MH/SUD), $50 not subject to deductible.	Thereafter, Office Visits: $50 copayment after deductible All Other Outpatient Services: $50 copayment after deductible
ABA Treatment for Autism Spectrum Disorder First 3 visits (any combination of PCP, Specialist, ABA, MH/SUD), $50 not subject to deductible. Preauthorization required.	Thereafter, $50 copayment after deductible
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations) First 3 visits (any combination of PCP, Specialist, ABA, MH/SUD), $50 not subject to deductible.	Thereafter, $50 copayment after deductible
Specialist Office Visits First 3 visits (any combination of PCP, Specialist, ABA, MH/SUD), $75 not subject to deductible. Referral required.	Thereafter, $75 copayment after deductible
Telemedicine Services	No Charge
Preventive Office Visits	

Benefits	In-Network (INET) Member Pays
Adult/Pediatric Preventive Visits	No Charge
Prenatal Care	No Charge
Routine Gynecological Services/Well Woman Exams, Mammography Screenings*	No Charge
Well-Baby and Well-Child Care, including Immunizations*	No Charge
All Other Preventive Services*	No Charge
***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)
Vasectomy	See surgical services
All other preventive services required by USPSTF and HRSA	No Charge
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI) Preauthorization required.	$175 copayment after deductible
Laboratory Services Preauthorization required.	$50 copayment after deductible
Non-Advanced Radiology (X-ray, Diagnostic) Preauthorization may be required.	$75 copayment after deductible
Preadmission Testing Preauthorization required.	$0 copayment after deductible
Second Opinions on the Diagnosis of Cancer, Surgery and Other First visit (any combination of PCP, Specialist, ABA, MH/SUD), $75 not subject to deductible. Referral required.	Thereafter, $75 copayment after deductible
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	$10 copayment after deductible
Non-preferred Generic Tier 2	$35 copayment after deductible

Benefits	In-Network (INET) Member Pays
Preferred Brand Tier 3	$70 copayment after deductible
Prescription – Mail Order Pharmacy (up to a 90-day supply per prescription)	
Preferred Generic Tier 1	$25 copayment after deductible
Non-preferred Generic Tier 2	$87.50 copayment after deductible
Preferred Brand Tier 3	$175 copayment after deductible
Outpatient Rehabilitative and Habilitative Services	
Physical and Occupational Therapy 60 visits per condition/plan year, combined therapies.	$50 copayment after deductible
Other Services	
Anesthesia Services	No Charge
Cardiac and Pulmonary Rehabilitation Preauthorization required for Inpatient services.	$50 copayment after deductible
Chemotherapy	$50 copayment after deductible
Chiropractic Services First 3 visits (any combination of PCP, Specialist, ABA, MH/SUD), $75 not subject to deductible.	Thereafter, $75 copayment after deductible
Diabetic Equipment and Supplies 90-day supply mail order available. Preauthorization may be required.	$50 copayment after deductible. Insulin copayment may not exceed $100 per 30-day supply.
Dialysis Referral required. Preauthorization may be required.	$50 copayment after deductible
Durable Medical Equipment (DME)	50% coinsurance after deductible
External Hearing Aids Single purchase once every 3 years. Preauthorization required.	50% coinsurance after deductible
Home Health Care 40 visits per plan year. Preauthorization required.	$50 copayment after deductible

Benefits	In-Network (INET) Member Pays
Outpatient Services (in a hospital or ambulatory facility) Preauthorization may be required.	$150 copayment 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.	$1,500 copayment after deductible, per admission
Inpatient Rehabilitation Services 60 days per condition/plan year, combined therapies. Preauthorization required.	$1,500 copayment after deductible, per admission
Inpatient Habilitation Services 60 days per condition/plan year, combined therapies. Preauthorization required.	$1,500 copayment after deductible, per admission
Emergency and Urgent Care	
Ambulance Services	$300 copayment after deductible
Emergency Room Waived if admitted to Hospital.	$500 copayment after deductible
Urgent Care Centers	$75 copayment after deductible
Pediatric Dental Care - up to age 19 end of month	
Preventive Dental Care 1 dental exam and cleaning per 6-month period.	$50 copayment after deductible
Routine Dental Care Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at 6-month intervals.	$50 copayment after deductible
Major Dental Care Preauthorization required.	$50 copayment after deductible
Orthodontia Preauthorization required.	$50 copayment after deductible
Pediatric Vision Care - up to age 19 end of month	
Contact Lens 1 set of prescribed lenses and frames per 12-month period.	50% coinsurance after deductible

Benefits	In-Network (INET) Member Pays
Prescription Eye Glasses 1 set of prescribed lenses and frames per 12-month period.	50% coinsurance after deductible
Routine Eye Exam 1 exam per 12-month period.	$50 copayment after deductible
Additional Covered Services	
Allergy Testing First 3 visits (any combination of PCP, Specialist, ABA, MH/SUD), $50/$75 not subject to deductible. Referral required.	Thereafter, Performed in a PCP Office: $50 copayment after deductible Performed in a Specialist Office: $75 copayment 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)
Important information	

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 network 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 policy form number 155-23-IOFFHIXSelectBSchedule (04/23), 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.

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

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**.