



**EmblemHealth Millennium Gold D**  
**Summary of Benefits**  
**Millennium Network - Referral Required**

PHGLDB015 / MH001280

<b>Deductible and Out-of-Pocket Maximum</b>	<b>In-Network (INET) Member Pays</b>
<b>Plan Deductible</b>	\$600 \$1,200
<b>Separate Prescription Drug Deductible</b>	None
<b>Out-of-Pocket Maximum</b>	\$5,900 \$11,800
<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>
<b>Provider Office Visits</b>	
<b>Mental Health and Substance Abuse Office Visits</b>	Office Visits: \$25 copayment after deductible All Other Outpatient Services: \$25 copayment after deductible
<b>ABA Treatment for Autism Spectrum Disorder</b> Preauthorization required.	\$25 copayment after deductible
<b>Primary Care Provider Office Visits</b> (includes services for illness, injury, follow-up care and consultations)	\$25 copayment after deductible
<b>Specialist Office Visits</b> Referral required.	\$40 copayment after deductible
<b>Telemedicine Services</b>	No Charge
<b>Preventive Office Visits</b>	
<b>Adult/Pediatric Preventive Visits</b>	No Charge
<b>Prenatal Care</b>	No Charge
<b>Routine Gynecological Services/Well Woman Exams, Mammography Screenings*</b>	No Charge
<b>Well-Baby and Well-Child Care, including Immunizations*</b>	No Charge
<b>All Other Preventive Services*</b>	No Charge

<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>
<b>*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF or HRSA</b>	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)
<b>Vasectomy</b>	See surgical services
<b>All other preventive services required by USPSTF and HRSA</b>	No Charge
<b>Outpatient Diagnostic Services</b>	
<b>Advanced Radiology</b> (CT/PET Scan, MRI) Preauthorization required.	\$40 copayment after deductible
<b>Laboratory Services</b> Preauthorization required.	Performed in a PCP Office: \$25 copayment after deductible Performed in a Specialist Office: \$40 copayment after deductible
<b>Non-Advanced Radiology</b> (X-ray, Diagnostic) Preauthorization may be required.	\$40 copayment after deductible
<b>Preadmission Testing</b> Preauthorization required.	\$0 copayment after deductible
<b>Second Opinions on the Diagnosis of Cancer, Surgery and Other</b> Referral required.	\$40 copayment after deductible
<b>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.</b>	
<b>Preferred Generic</b> Tier 1	\$10 copayment not subject to deductible
<b>Non-preferred Generic</b> Tier 2	\$35 copayment not subject to deductible
<b>Preferred Brand</b> Tier 3	\$70 copayment not subject to deductible
<b>Prescription - Mail Order Pharmacy (up to a 90-day supply per prescription)</b>	
<b>Preferred Generic</b> Tier 1	\$25 copayment not subject to deductible
<b>Non-preferred Generic</b> Tier 2	\$87.50 copayment not subject to deductible
<b>Preferred Brand</b> Tier 3	\$175 copayment not subject to deductible
<b>Outpatient Rehabilitative and Habilitative Services</b>	

Benefits	In-Network (INET) Member Pays
<b>Physical and Occupational Therapy</b> 60 visits per condition/plan year, combined therapies.	\$30 copayment after deductible
<b>Other Services</b>	
<b>Anesthesia Services</b>	No Charge
<b>Cardiac and Pulmonary Rehabilitation</b> Preauthorization required for Inpatient services.	\$25 copayment after deductible
<b>Chemotherapy</b>	\$25 copayment after deductible
<b>Chiropractic Services</b>	\$40 copayment after deductible
<b>Diabetic Equipment and Supplies</b> 90-day supply mail order available. Preauthorization may be required.	\$25 copayment after deductible. Insulin copayment may not exceed \$100 per 30-day supply.
<b>Dialysis</b> Referral required. Preauthorization may be required.	\$25 copayment after deductible
<b>Durable Medical Equipment (DME)</b>	20% coinsurance after deductible
<b>External Hearing Aids</b> Single purchase once every 3 years. Preauthorization required.	20% coinsurance after deductible
<b>Home Health Care</b> 40 visits per plan year. Preauthorization required.	\$25 copayment after deductible
<b>Outpatient Services</b> (in a hospital or ambulatory facility) Preauthorization may be required.	\$100 copayment after deductible
<b>Inpatient Services</b>	
<b>Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility and all IP settings</b> Preauthorization required, except for emergency admissions.	\$1,000 copayment after deductible, per admission
<b>Inpatient Rehabilitation Services</b> 60 days per condition/plan year, combined therapies. Preauthorization required.	\$1,000 copayment after deductible, per admission

<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>
<b>Inpatient Habilitation Services</b> 60 days per condition/plan year, combined therapies. Preauthorization required.	\$1,000 copayment after deductible, per admission
<b>Emergency and Urgent Care</b>	
<b>Ambulance Services</b>	\$150 copayment after deductible
<b>Emergency Room</b> Waived if admitted to Hospital.	\$150 copayment after deductible
<b>Urgent Care Centers</b>	\$60 copayment after deductible
<b>Pediatric Dental Care - up to age 19 end of month</b>	
<b>Preventive Dental Care</b> 1 dental exam and cleaning per 6-month period.	\$25 copayment after deductible
<b>Routine Dental Care</b> Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at 6-month intervals.	\$25 copayment after deductible
<b>Major Dental Care</b> Preauthorization required.	\$25 copayment after deductible
<b>Orthodontia</b> Preauthorization required.	\$25 copayment after deductible
<b>Pediatric Vision Care - up to age 19 end of month</b>	
<b>Contact Lens</b> 1 set of prescribed lenses and frames per 12-month period.	20% coinsurance after deductible
<b>Prescription Eye Glasses</b> 1 set of prescribed lenses and frames per 12-month period.	20% coinsurance after deductible
<b>Routine Eye Exam</b> 1 exam per 12-month period.	\$25 copayment after deductible
<b>Additional Covered Services</b>	
<b>Allergy Testing</b> Referral required.	Performed in a PCP Office: \$25 copayment after deductible Performed in a Specialist Office: \$40 copayment after deductible
<b>Gym Reimbursement</b> 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 Millennium 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-IOFFHIXMillenniumGSchedule (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.



**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).