EmblemHealth

EmblemHealth EPO Value

Effective Date: August 1, 2021

Benefit Summary
Bridge Network

COST SHARING HIGHLIGHTS		IN NETWORK	OUT of NETWORK	LIMITATIONS
Benefit Period		Plan Year	Not Applicable	
Medical Deductible		$1,000 Individual / $2,000 Family	Not Applicable	
Medical Coinsurance		20%	Not Applicable	
Out-of-Pocket Limit		$7,150 Individual / $14,300 Family	Not Applicable	
PCP Office Visits		$30 Copayment	Not Covered	
Specialist Office Visits		$50 Copayment	Not Covered	
Hospital Admission		20% coinsurance, after deductible	Not Covered	
Emergency Room		$250 Copayment	Use In Network cost sharing	ER cost sharing waived if admitted
Prescription Drug Deductible		$100 Individual / $200 Family	Not Applicable	Applies to Tier 1, Tier 2, and Tier 3 drugs
Retail Prescription Drugs (30-day supply)	Tier 1	$25 Copayment, after deductible	Not Covered	
	Tier 2	$50 Copayment, after deductible	Not Covered	
	Tier 3	$100 Copayment, after deductible	Not Covered	
Mail Order Prescription Drugs (90-day supply)	Tier 1	$62.50 Copayment, after deductible	Not Covered	
	Tier 2	$125 Copayment, after deductible	Not Covered	
	Tier 3	$250 Copayment, after deductible	Not Covered	
MATERNITY AND NEW BORN CARE		**IN NETWORK**	**OUT of NETWORK**	**LIMITATIONS**
Prenatal and Postnatal Care		Covered in full	Not Covered	As required by USPSTF and HRSA guidelines
Inpatient Hospital Services and Birthing Center		Covered in full	Not Covered	One (1) home care visit Covered, at no cost, if discharged early
Physician and Midwife Services for Delivery		Covered in full	Not Covered	
Breast Pump		Covered in full	Not Covered	Covered for duration of breast feeding

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Bridge Network

INPATIENT HOSPITAL SERVICES	IN NETWORK	OUT of NETWORK	LIMITATIONS
Inpatient Hospital Services	20% coinsurance, after deductible	Not Covered	
Inpatient Habilitation & Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	20% coinsurance, after deductible	Not Covered	Habilitation 60 days, combined therapies Rehabilitation 60 days, combined therapies per plan year
Skilled Nursing Facility	Covered in full, after deductible	Not Covered	60 day limit per plan year
Hospice Care	Covered in full	Not Covered	210 days per plan year
OUTPATIENT HOSPITAL SERVICES	**IN NETWORK**	**OUT of NETWORK**	**LIMITATIONS**
Preadmission Testing	Covered in full	Not Covered	
Ambulatory Surgery Center Facility	$400 Copayment	Not Covered	
Outpatient Hospital Surgery Facility	$400 Copayment	Not Covered	
Home Health Care	Covered in full	Not Covered	40 visits per plan year
PHYSICIAN SURGICAL SERVICES	**IN NETWORK**	**OUT of NETWORK**	**LIMITATIONS**
Inpatient Hospital Surgery	Covered in full	Not Covered	
Outpatient Hospital Surgery	Covered in full	Not Covered	
Surgery performed at Ambulatory Facility	Covered in full	Not Covered	
Surgery performed in a PCP Office	$30 Copayment	Not Covered	
Surgery performed in a Specialist Office	$50 Copayment	Not Covered	
OUTPATIENT MEDICAL CARE	**IN NETWORK**	**OUT of NETWORK**	**LIMITATIONS**
PCP Office Visits	$30 Copayment	Not Covered	
Specialists Office Visits	$50 Copayment	Not Covered	
Telemedicine Program Provided by a Telemedicine Physician	$30 Copayment	Not Covered	
Chiropractic Services	$50 Copayment	Not Covered	
Acupuncture	$20 Copayment	Not Covered	20 visits per calendar year
Preventive Care (Well-child visits, adult annual physicals, well woman exams, prostate screenings, preventive services required by USPTF and HRSA)	Covered in full	Not Covered	

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EmblemHealth EPO Value

Effective Date: August 1, 2021

Benefit Summary
Bridge Network

OUTPATIENT MEDICAL CARE *cont'd*	IN NETWORK	OUT of NETWORK	LIMITATIONS
Allergy Testing and Treatment			
• Performed in a PCP Office	$30 Copayment	Not Covered	
• Performed in a Specialist Office	$50 Copayment	Not Covered	
Laboratory Procedures			
• Performed in a PCP Office	$40 Copayment	Not Covered	
• Performed in a Specialist Office	$40 Copayment	Not Covered	
• Performed in a Freestanding Facility	$50 Copayment	Not Covered	
• Performed as Outpatient Hospital Services	$50 Copayment	Not Covered	
Diagnostic Testing			
• Performed in a PCP Office	$40 Copayment	Not Covered	
• Performed in a Specialist Office	$40 Copayment	Not Covered	
• Performed as Outpatient Hospital Services	$50 Copayment	Not Covered	
Diagnostic Radiology			
• Performed in a PCP Office	$40 Copayment	Not Covered	
• Performed in a Specialist Office	$40 Copayment	Not Covered	
• Performed in a Freestanding Facility	$50 Copayment	Not Covered	
• Performed as Outpatient Hospital Services	$50 Copayment	Not Covered	
Advanced Imaging Services (PET scans, MRI, nuclear medicine, CAT scans)			
• Performed in a Specialist Office	$50 Copayment	Not Covered	
• Performed in a Freestanding Facility	$50 Copayment	Not Covered	
• Performed as Outpatient Hospital Services	$50 Copayment	Not Covered	

EmblemHealth

EmblemHealth EPO Value

Effective Date: August 1, 2021

Benefit Summary
Bridge Network

OUTPATIENT MEDICAL CARE *cont'd*	IN NETWORK	OUT of NETWORK	LIMITATIONS
Outpatient Habilitation and Rehabilitation (Physical Therapy, Occupational Therapy or Speech Therapy)			Habilitation 30 visits, combined therapies Rehabilitation 30 visits, combined therapies per plan year
• Performed in a PCP Office	$30 Copayment	Not Covered	
• Performed in a Specialist Office	$50 Copayment	Not Covered	
• Performed as Outpatient Hospital Services	Covered in full	Not Covered	
Cardiac and Pulmonary Rehabilitation			Specialist and Outpatient Hospital Services limited to 32 visits, combined per plan year
• Performed in a Specialist Office	$50 Copayment	Not Covered	
• Performed as Outpatient Hospital Services	Covered in full	Not Covered	
• Performed as Inpatient Hospital Services	20% coinsurance, after deductible	Not Covered	
Infusion Therapy			
• Performed in a PCP Office	$30 Copayment	Not Covered	
• Performed in a Specialist Office	$50 Copayment	Not Covered	
• Performed as Outpatient Hospital Services	Covered in full	Not Covered	
• Home Infusion Therapy	$50 Copayment	Not Covered	
Therapeutic Radiology Services			
• Performed in a Specialist Office	$40 Copayment	Not Covered	
• Performed in a Freestanding Facility	$50 Copayment	Not Covered	
• Performed as Outpatient Hospital Services	$50 Copayment	Not Covered	
Chemotherapy and Immunotherapy			
• Performed in a PCP Office	$30 Copayment	Not Covered	
• Performed in a Specialist Office	$50 Copayment	Not Covered	
• Performed as Outpatient Hospital Services	Covered in full	Not Covered	

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Bridge Network

OUTPATIENT MEDICAL CARE *cont'd*	IN NETWORK	OUT of NETWORK	LIMITATIONS
Dialysis Treatment			
• Performed in a PCP Office	$30 Copayment	Not Covered	
• Performed in a Specialist Office	$50 Copayment	Not Covered	
• Performed in a Freestanding Facility	$50 Copayment	Not Covered	
• Performed as Outpatient Hospital Services	Covered in full	Not Covered	
ABA Treatment for Autism Spectrum Disorder	$30 Copayment	Not Covered	
Assistive Communication Devices for Autism Spectrum Disorder	$30 Copayment	Not Covered	
Second Opinions on the diagnosis of cancer, surgery and other	Covered in full	Not Covered	Cancer second opinion covered out of network at in network cost sharing
Diabetic Equipment and Supplies	$30 Copayment	Not Covered	Up to a 30-day supply
Insulin and Oral Agents	$30 Copayment	Not Covered	Up to a 30-day supply
Diabetes Education	$30 Copayment	Not Covered	
Vasectomy	$50 Copayment	Not Covered	
Infertility Diagnosis and Treatment	Subject To Applicable cost sharing	Not Covered	Three (3) IVF Cycles, per lifetime
Durable Medical Equipment and Braces	Covered in full	Not Covered	
Prosthetics and Orthotics	Covered in full	Not Covered	
Medical Supplies	Covered in full	Not Covered	
Cochlear Implants	Covered in full	Not Covered	One (1) per ear per plan year
MENTAL HEALTH	**IN NETWORK**	**OUT of NETWORK**	**LIMITATIONS**
Mental Health Care			Unlimited days/visits
• Inpatient	20% coinsurance, after deductible	Not Covered	
• Outpatient	$30 Copayment	Not Covered	

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SUBSTANCE USE	IN NETWORK	OUT of NETWORK	LIMITATIONS
Substance Use Services			Unlimited days/visits
• Inpatient	20% coinsurance, after deductible	Not Covered	
• Outpatient	$30 Copayment	Not Covered	
EMERGENCY CARE	**IN NETWORK**	**OUT of NETWORK**	**LIMITATIONS**
Urgent Care Center	$50 Copayment	Not Covered	
Emergency Room	$250 Copayment	Use In Network cost sharing	ER cost sharing waived if admitted
Pre-Hospital Emergency Medical Services (Ambulance Services)	$250 Copayment	Use In Network cost sharing	
Non-Emergency Ambulance Services	$250 Copayment	Not Covered	
VISION CARE	**IN NETWORK**	**OUT of NETWORK**	**LIMITATIONS**
Eye Exams	$50 Copayment	Not Covered	One (1) routine eye exam by an optometrist per calendar year
Eyeglasses	Not Covered	Not Covered	
OPTIONAL BENEFITS	**IN NETWORK**	**OUT of NETWORK**	**LIMITATIONS**
External Hearing Aids	Not Covered	Not Covered	
Preventive Dental Care	Not Covered	Not Covered	
Gym Reimbursement	$200 per six (6) month calendar year period	$200 per six (6) month calendar year period	

FOOTNOTES

For plans with services subject to a deductible, the deductible must be met before copay/coinsurance applies. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Covered drugs are dispensed in accordance with EmblemHealth's Drug Formulary.

Except for emergency care, the above benefits and services are covered only when provided by an EmblemHealth Participating Physician. EmblemHealth Participating Physicians and Providers have contracted with EmblemHealth to provide care to our members; they are not employees, agents, servants or representatives of EmblemHealth.

Underwritten by EmblemHealth Insurance Company. Refer to policy form 151-23-LGEPOSCHEDULE (07/20), et al. This summary is provided for information only; it does not contain complete details of the Plan which are available only in the Contract or Certificate of Coverage and Schedule of Benefits, and it does not constitute an Agreement.