EmblemHealth

SUMMARY OF BENEFITS

Prime *HMO*

HIP Prime Network for NY CT and NJ Residents

➢ MAJOR COST SHARING PROVISIONS	PARTICIPATING PROVIDER
Benefit Period	Plan Year
Maximum Out-of-Pocket Limit	$6,600 Individual / $13,200 Family
Medical Deductible	Not Applicable
PCP Office visits	$10 Copayment
Specialist Office visits	$20 Copayment
Hospital admission	$100 Copayment
Emergency Room copay (waived if Hospital admission)	$75 Copayment
Prescription Drug Deductible	Not Applicable
Prescription drugs – 30 day supply	$10 generic / $25 brand / $50 non-formulary
Prescription drugs – 90 day supply	$15 generic / $37.50 brand / $75 non-formulary
➢ INPATIENT HOSPITAL SERVICES	PARTICIPATING PROVIDER
• Hospital and physician services	Subject to Hospital Admission Copayment Physician Services Covered in Full
• Semi-private room and board	Included in Hospital Admission Copayment
• Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs,anesthesia, X-rays, lab tests, mastectomy care, cardiac and pulmonary rehabilitation and end of life care	Included in Hospital Admission Copayment
• Inpatient Rehabilitation & Habilitation Services (Physical,Speech and Occupational Therapy)	Subject to Hospital Admission Copayment; 90 days combined therapies
• Human organ transplants	Included in Hospital Admission Copayment
➢ MATERNITY AND NEW BORN CARE	PARTICIPATING PROVIDER
• Prenatal care	Covered in full
• Inpatient Hospital Services and Birthing Center	$100 Copayment
• Physician and Midwife Services for Delivery	Covered In Full
• Breast Pump	Covered in full
• Postnatal care	Covered in full

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➢ SURGICAL SERVICES	PARTICIPATING PROVIDER
• Inpatient Hospital Surgery	Covered in full
• Outpatient Hospital Surgery	Covered in full
• Surgery performed in a PCP Office	Covered in full
• Surgery performed in a Specialist Office	Covered in full
• Surgery performed at an Ambulatory Surgical Center	Covered in full
➢ CARDIAC REHABILITATION	PARTICIPATING PROVIDER
• Performed as Inpatient Hospital Services	Included as part of Inpatient Hospital Service Cost-Sharing
• Performed as Outpatient Hospital Services	$20 Copayment ; 32 visits, combined with Specialist Office limits
• Performed in a Specialist Office	$20 Copayment ; 32 visits, combined with Outpatient Hospital limits
➢ OUTPATIENT MEDICAL CARE	PARTICIPATING PROVIDER
• PCP office visits	$10 Copayment
• Specialists office visits	$20 Copayment
• Preventive care, including well-child visits and immunizations, adult annual physical examinations, adult immunizations, routine gynecological services/well woman exams, mammograms, screening and diagnostic imaging for the detection of breast cancer, sterilization procedures for women, and bone density testing	Covered in full
• Laboratory Procedures, • Performed in a PCP Office • Performed in Specialist Office • Performed in a Free Standing Laboratory • Performed as Outpatient Hospital Services	 Covered in full Covered in full Covered in full Covered in full
• Diagnostic Radiology • Performed in a PCP Office • Performed in Specialist Office • Performed in a Free Standing Radiology Facility • Performed as Outpatient Hospital Services	 Covered in full Covered in full Covered in full Covered in full
• Diagnostic Testing • Performed in a PCP Office	 Covered in full

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OUTPATIENT MEDICAL CARE	PARTICIPATING PROVIDER
• Performed in Specialist Office	Covered in full
• Performed as Outpatient Hospital Services	Covered in full
• Advanced Imaging Services (PET scans, MRI, nuclear medicine, CAT scans)	
• Performed in a Specialist Office	Covered in full
• Performed in a Free Standing Radiology Facility	Covered in full
• Performed as Outpatient Hospital Services	Covered in full
• Infusion Therapy	
• Performed in a PCP Office	Covered in full
• Performed in a Specialist Office Referral required	Covered in full
• Performed as Outpatient Hospital Services	Covered in full
• Home Infusion Therapy	Covered in full
• Ambulatory surgery center facility	$100 Copayment
• Outpatient hospital surgery facility	$100 Copayment
• Preadmission testing	Covered in full
• Second opinions on the diagnosis of cancer, surgery and other	Covered in full
• Outpatient Habilitation Services	90 visits, combined therapies
• Performed in a PCP Office	$10 Copayment
• Performed in a Specialist Office	$20 Copayment
• Performed as Outpatient Hospital Services	$20 Copayment
• Radiation therapy	
• Performed in a Specialist Office	Covered in full
• Performed in a Free Standing Radiology Facility	Covered in full
• Performed as Outpatient Hospital Services	Covered in full

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➢ OUTPATIENT MEDICAL CARE	PARTICIPATING PROVIDER
• Chemotherapy	
• Performed in a PCP Office	Covered in full
• Performed in a Specialist Office	Covered in full
• Performed as Outpatient Hospital Services	Covered in full
• Outpatient Rehabilitation Services(physical therapy,occupational therapy, speech therapy, pulmonary rehabilitation)	90 visits, combined therapies
• Performed in a PCP Office	$10 Copayment
• Performed in a Specialist Office	$20 Copayment
• Performed as Outpatient Hospital Services	$20 Copayment
• Allergy Testing and Treatment	
• Performed in a PCP Office	$10 Copayment
• Performed in a Specialist Office	$20 Copayment
• Acupuncture	Not Covered
• Telemedicine Program Provided by a Telemedicine Physician	Not Covered
➢ MENTAL HEALTH AND ALCOHOL AND SUBSTANCE USE SERVICES	PARTICIPATING PROVIDER
• **Mental Health Care**	
• Inpatient	$100 Copayment, Unlimited Days
• Outpatient	$10 Copayment, Unlimited Visits
• **Substance Use Services**	
• Inpatient	$100 Copayment, Unlimited Days
• Outpatient	$10 Copayment
➢ SPECIAL KINDS OF CARE	PARTICIPATING PROVIDER
Urgent Care Center	$10 Copayment
Non-Emergency Ambulance Services	Covered in full
Pre-Hospital Emergency Medical Services (Ambulance Services)	Covered in full

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SPECIAL KINDS OF CARE	PARTICIPATING PROVIDER
Home health care	Covered in full; 200 visits
Hospice care	Covered in full, 210 days
Skilled Nursing Facility (including cardiac and pulmonary rehabilitation)	Covered in full, 120 Day Limit
Dialysis treatment	
• Performed in PCP Office	$10 Copayment
• Performed in Specialist Office	$10 Copayment
• Performed in Free Standing Center	$10 Copayment
• Performed as Outpatient Hospital Services	$10 Copayment
Diabetes equipment, supplies, Insulin and education	$10 Copayment/ Insulin $0 Copayment
Chiropractic Services	$20 Copayment
Family Planning Services	Covered
Vasectomy	$20 Copayment
Infertility Diagnosis and Treatment	3 Cycles IVF, Per Lifetime, Subject To Applicable Copayment
Dental Care **• Preventive Dental**	Preventive Not Included
Durable Medical Equipment and Braces	No Deductible, Covered In Full
Prosthetics	Covered In Full
Orthotics	Covered In Full
Medical Supplies	Covered in full
External Hearing Aids	Not Covered
Cochlear Implants	No Copayment - One (1) per ear per time Covered
Optical Care	
• Refractive Eye Exams	Covered in full / Once per covered period
• Eyeglasses	Eyeglasses $35 Every 24 Months
ABA Treatment for Autism Spectrum Disorder	$10 Copayment
Assistive Communication Devices for Autism Spectrum Disorder	$10 Copayment

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ADDITIONAL BENEFITS	PARTICIPATING PROVIDER
• Nurse Advice Line	Covered
• WellSpark	Health Risk Assessment
• Gym Reimbursement	Not Covered

FOOTNOTES

Drugs are dispensed in accordance with EmblemHealth's Drug Formulary. Please refer to your Prescription Drug Rider for details.

The member does not have OON coverage, and is only covered for OON services if performed in An Emergency situation or if referred by a participating provider.

EmblemHealth Participating Physicians and Providers have contracted with EmblemHealth Insurance Company 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 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.

Prime HMO is underwritten by EmblemHealth Insurance Company, an EmblemHealth Company