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** | $6,850 Individual / $13,700 Family |
| **Medical Deductible** | Not Applicable |
| **PCP Office visits** | $30 Copayment |
| **Specialist Office visits** | $35 Copayment |
| **Hospital admission** | $500 Copayment |
| **Emergency Room copay (waived if Hospital admission)** | $100 Copayment |
| **Prescription Drug Deductible** | Not Applicable |
| **Prescription drugs – 30 day supply** | $25 generic / $50 brand / $100 non-formulary |
| **Prescription drugs – 90 day supply** | $37.50 generic / $75 brand / $150 non-formulary |
| ➢ INPATIENT HOSPITAL SERVICES | PARTICIPATING PROVIDER |
| • Hospital and physician services | Subject to Hospital Admission Copayment<br>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 | $500 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 | $35 Copayment ; 32 visits, combined with Specialist Office limits |
| • Performed in a Specialist Office | $35 Copayment ; 32 visits, combined with Outpatient Hospital limits |
| ➢ OUTPATIENT MEDICAL CARE | PARTICIPATING PROVIDER |
| • PCP office visits | $30 Copayment |
| • Specialists office visits | $35 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,<br>• Performed in a PCP Office<br>• Performed in Specialist Office<br>• Performed in a Free Standing Laboratory<br>• Performed as Outpatient Hospital Services | <br>Covered in full<br>Covered in full<br>Covered in full<br>Covered in full |
| • Diagnostic Radiology<br>• Performed in a PCP Office<br>• Performed in Specialist Office<br>• Performed in a Free Standing Radiology Facility<br>• Performed as Outpatient Hospital Services | <br>Covered in full<br>Covered in full<br>Covered in full<br>Covered in full |
| • Diagnostic Testing<br>• Performed in a PCP Office | <br>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 | $75 Copayment |
| • Outpatient hospital surgery facility | $75 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 | $30 Copayment |
| • Performed in a Specialist Office | $35 Copayment |
| • Performed as Outpatient Hospital Services | $35 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 | $30 Copayment |
| • Performed in a Specialist Office | $35 Copayment |
| • Performed as Outpatient Hospital Services | $35 Copayment |
| • Allergy Testing and Treatment | |
| • Performed in a PCP Office | $30 Copayment |
| • Performed in a Specialist Office | $35 Copayment |
| • Acupuncture | Not Covered |
| • Telemedicine Program Provided by a Telemedicine Physician | Virtual General Medical session available 24/7, on-demand - $25 Copayment |
| **➢ MENTAL HEALTH AND ALCOHOL AND SUBSTANCE USE SERVICES** | **PARTICIPATING PROVIDER** |
| • **Mental Health Care** | |
| • Inpatient | $500 Copayment , Unlimited Days |
| • Outpatient | $25 Copayment, Unlimited Visits |
| • **Substance Use Services** | |
| • Inpatient | $500 Copayment, Unlimited Days |
| • Outpatient | $25 Copayment |
| **➢ SPECIAL KINDS OF CARE** | **PARTICIPATING PROVIDER** |
| **Urgent Care Center** | $30 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, Unlimited Days |
| **Dialysis treatment** | |
| • Performed in PCP Office | $25 Copayment |
| • Performed in Specialist Office | $25 Copayment |
| • Performed in Free Standing Center | $25 Copayment |
| • Performed as Outpatient Hospital Services | $25 Copayment |
| **Diabetes equipment, supplies, Insulin and education** | $25 Copayment |
| **Chiropractic Services** | $35 Copayment |
| **Family Planning Services** | Covered |
| **Vasectomy** | $35 Copayment |
| **Infertility Diagnosis and Treatment** | 3 Cycles IVF, Per Lifetime, Subject To Applicable Copayment |
| **Dental Care**<br>**• Preventive Dental** | Preventive Not Included |
| **Durable Medical Equipment and Braces** | $25 Deductible, Covered In Full |
| **Prosthetics** | $25 Deductible, Covered In Full |
| **Orthotics** | $25 Deductible, 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 | $10 Copayment / Once per covered period |
| • Eyeglasses | Eyeglasses $35 Every 24 Months |
| **ABA Treatment for Autism Spectrum Disorder** | $25 Copayment |
| **Assistive Communication Devices for Autism Spectrum Disorder** | $25 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*