EmblemHealth®

SUMMARY OF BENEFITS

➢ MAJOR COPAYMENT PROVISIONS	HIP PRIME™
PCP Office visits	$10 copay per visit
Specialist Office visits	$10 copay per visit
Hospital admission	$100 copay per Hospital Admission
Emergency room copay (waived if admitted)	$25 copay per visit
Prescription drugs	$10 generic / $10 brand (Subject to Drug Formulary) Contraceptives Included (Formulary copays are reduced by 50% when utilizing the HIP Mail Order Pharmacy Service. Up to a 90 day supply may be obtained.)

➢ INPATIENT HOSPITAL SERVICES	HIP PRIME™
• Hospital and Physician Services	Subject to Hospital admission copay
• Semi-private Room and Board	Included in Hospital Admission copay
• Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, X-rays and lab tests	Included in Hospital Admission copay
• Short-term speech, physical, occupational and respiratory therapy (when part of an acute admission)	Included in Hospital Admission copay Short-term only
• Speech, physical, occupational and respiratory therapy (when part of a rehabilitation admission)	Subject to Hospital admission copay 90 days per plan year
• Radiation therapy and chemotherapy	Included in Hospital Admission copay
• Pre-admission testing	Included in Hospital Admission copay
• Human organ transplants	Included in Hospital Admission copay

➢ OUTPATIENT MEDICAL CARE	HIP PRIME™
• PCP office visits	Subject to PCP office visit copay
• Specialist office visits	Subject to Specialist office visit copay
• Preventive care, including physical exams, ear exams, health education and counseling, pap smear, mammography and immunizations	$0 Copay
• Well-child care	No copay
• Diagnostic services including X-ray, lab tests, EKG's	Included in PCP office visit copay
• Prenatal, postnatal care in physician's office	No copay
• Ambulatory surgery	$50 copay per visit
• Second medical and surgical opinion	No copay
• Routine foot care	Not covered
• Chiropractic services	Subject to Specialist office visit copay

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SUMMARY OF BENEFITS

➢ MENTAL HEALTH AND SUBSTANCE USE DISORDER	HIP PRIME™
Mental Health Care	
• **Inpatient**	
- Treatment of Mental Illness	Subject to Hospital admission copay; Unlimited days per plan year
• **Outpatient**	
- Treatment of Mental Illness	$10 copay Unlimited Visits per plan year
Substance Use Disorder • Inpatient Detoxification	Subject to Hospital admission copay No limit on days per plan year
• Inpatient Rehabilitation Treatment	Subject to Hospital admission copay Unlimited days per plan year
• Outpatient Rehabilitation Treatment	$10 Copay per visit, Unlimited Visit - per plan year

➢ SPECIAL KINDS OF CARE	HIP PRIME™
Emergency and urgent Care	
• In hospital emergency room	Subject to Emergency room copay
• In urgent care facility	Subject to PCP office visit copay
• In physician's office	Subject to PCP office visit copay
• Ambulance service to the hospital	No copay
Home Health Care	No copay; 200 visits per plan year
Hospice Care	No copay; 210 days
Skilled Nursing Facility care	$0 copay; Unlimited days per plan year
Dialysis treatment	$10 copay per visit
Diabetes equipment, supplies and education	$10 copay per month
Outpatient physical, speech, occupational and respiratory therapy.	Subject to Specialist office visit copay; 90 visits per plan year
Family Planning Services	Covered
Infertility Diagnosis and Treatment	Subject to applicable copays
In-vitro Fertilization	IVF 3 Cycle limit per lifetime, subject to applicable copay
Dental Care • General dental care	Covered at reduced member fee schedule

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EmblemHealth®

SUMMARY OF BENEFITS

• Preventive dental care - Oral exam (One every six months) - Cleaning (One every six months) - Topical application of fluoride for children age 16 and under (One every six months) - Fluoride applications age 17 and over (One every six months)	 $5 copay per visit $10 copay per visit $5 copay per visit Copay to be determined by zip code
Durable Medical Equipment	$0 annual deductible
Private Duty Nursing	Covered in full
Hearing aids	Not covered; Cochlear implants covered
Optical care	
• Refractive Eye Exams	$10 copay
• Eyeglasses	Every 24 months:$80 frame allowance;$35 co-pay for lenses

➢ ADDITIONAL BENEFITS	HIP PRIME™
• Nurse Advice Line	Not Covered
• Wellness Rider	Not Covered
• Maximum Out of Pocket(MOOP)	Individual $6,600/Family $13,200
• Telemedicine	Not Covered

FOOTNOTES

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

Except for emergency care, the above benefits and services are covered only when provided or referred by a HIP Primary Care Physician and/or approved in advance by the HIP Care Management Program. HIP Participating Physicians and Providers have contracted with HIP to provide care to our members; they are not employees, agents, servants or representatives of HIP. 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.
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