



# SUMMARY OF BENEFITS

## Prime HMO

*HIP Prime Network for NY CT and NJ Residents*

### EASTERN SUFFOLK BOCES SUBGROUP

1102104

➤ 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	\$30 Copayment
Specialist Office visits	\$75 Copayment
Hospital admission	\$2,000 Copayment
Emergency Room copay (waived if Hospital admission)	\$500 Copayment
Prescription Drug Deductible	Not Applicable
Prescription drugs – 30 day supply	\$15 generic
Prescription drugs – 90 day supply	\$22.50 generic
➤ INPATIENT HOSPITAL SERVICES	PARTICIPATING PROVIDER
<ul style="list-style-type: none"> <li>Hospital and physician services</li> </ul>	Subject to Hospital Admission Copayment Physician Services Covered in Full
<ul style="list-style-type: none"> <li>Semi-private room and board</li> </ul>	Included in Hospital Admission Copayment
<ul style="list-style-type: none"> <li>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</li> </ul>	Included in Hospital Admission Copayment
<ul style="list-style-type: none"> <li>Inpatient Rehabilitation &amp; Habilitation Services (Physical, Speech and Occupational Therapy)</li> </ul>	Subject to Hospital Admission Copayment; 30 days combined therapies
<ul style="list-style-type: none"> <li>Human organ transplants</li> </ul>	Included in Hospital Admission Copayment
➤ MATERNITY AND NEW BORN CARE	PARTICIPATING PROVIDER
<ul style="list-style-type: none"> <li>Prenatal care</li> </ul>	Covered in full
<ul style="list-style-type: none"> <li>Inpatient Hospital Services and Birthing Center</li> </ul>	\$1,000 Copayment
<ul style="list-style-type: none"> <li>Physician and Midwife Services for Delivery</li> </ul>	Covered In Full
<ul style="list-style-type: none"> <li>Breast Pump</li> </ul>	Covered in full
<ul style="list-style-type: none"> <li>Postnatal care</li> </ul>	Covered in full



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<b>➤ SURGICAL SERVICES</b>	<b>PARTICIPATING PROVIDER</b>
• 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
<b>➤ CARDIAC REHABILITATION</b>	<b>PARTICIPATING PROVIDER</b>
• Performed as Inpatient Hospital Services	Included as part of Inpatient Hospital Service Cost-Sharing
• Performed as Outpatient Hospital Services	\$75 Copayment ; 32 visits, combined with Specialist Office limits
• Performed in a Specialist Office	\$75 Copayment ; 32 visits, combined with Outpatient Hospital limits
<b>➤ OUTPATIENT MEDICAL CARE</b>	<b>PARTICIPATING PROVIDER</b>
• PCP office visits	\$30 Copayment
• Specialists office visits	\$75 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, <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in Specialist Office</li> <li>• Performed in a Free Standing Laboratory</li> <li>• Performed as Outpatient Hospital Services</li> </ul>	Covered in full Covered in full Covered in full Covered in full
• Diagnostic Radiology <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in Specialist Office</li> <li>• Performed in a Free Standing Radiology Facility</li> <li>• Performed as Outpatient Hospital Services</li> </ul>	Covered in full Covered in full Covered in full Covered in full
• Diagnostic Testing <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> </ul>	Covered in full



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➤ OUTPATIENT MEDICAL CARE	PARTICIPATING PROVIDER
<ul style="list-style-type: none"> <li>• Performed in Specialist Office</li> <li>• Performed as Outpatient Hospital Services</li> </ul>	<p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p>
<ul style="list-style-type: none"> <li>• Advanced Imaging Services (PET scans, MRI, nuclear medicine, CAT scans)               <ul style="list-style-type: none"> <li>• Performed in a Specialist Office</li> <li>• Performed in a Free Standing Radiology Facility</li> <li>• Performed as Outpatient Hospital Services</li> </ul> </li> </ul>	<p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p>
<ul style="list-style-type: none"> <li>• Infusion Therapy               <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office Referral required</li> <li>• Performed as Outpatient Hospital Services</li> <li>• Home Infusion Therapy</li> </ul> </li> </ul>	<p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p>
<ul style="list-style-type: none"> <li>• Ambulatory surgery center facility</li> </ul>	<p style="text-align: center;">\$750 Copayment</p>
<ul style="list-style-type: none"> <li>• Outpatient hospital surgery facility</li> </ul>	<p style="text-align: center;">\$750 Copayment</p>
<ul style="list-style-type: none"> <li>• Preadmission testing</li> </ul>	<p style="text-align: center;">Covered in full</p>
<ul style="list-style-type: none"> <li>• Second opinions on the diagnosis of cancer, surgery and other</li> </ul>	<p style="text-align: center;">Covered in full</p>
<ul style="list-style-type: none"> <li>• Outpatient Habilitation Services               <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office</li> <li>• Performed as Outpatient Hospital Services</li> </ul> </li> </ul>	<p style="text-align: center;">30 visits, combined therapies</p> <p style="text-align: center;">\$30 Copayment</p> <p style="text-align: center;">\$75 Copayment</p> <p style="text-align: center;">\$75 Copayment</p>
<ul style="list-style-type: none"> <li>• Radiation therapy               <ul style="list-style-type: none"> <li>• Performed in a Specialist Office</li> <li>• Performed in a Free Standing Radiology Facility</li> <li>• Performed as Outpatient Hospital Services</li> </ul> </li> </ul>	<p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p>



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<ul style="list-style-type: none"> <li>Chemotherapy               <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul> </li> </ul>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>
<ul style="list-style-type: none"> <li>Outpatient Rehabilitation Services(physical therapy, occupational therapy, speech therapy, pulmonary rehabilitation)               <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul> </li> </ul>	<p>30 visits, combined therapies</p> <p>\$30 Copayment</p> <p>\$75 Copayment</p> <p>\$75 Copayment</p>
<ul style="list-style-type: none"> <li>Allergy Testing and Treatment               <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul> </li> </ul>	<p>\$30 Copayment</p> <p>\$75 Copayment</p>
<ul style="list-style-type: none"> <li>Acupuncture</li> </ul>	Not Covered
<ul style="list-style-type: none"> <li>Telemedicine Program Provided by a Telemedicine Physician</li> </ul>	Not Covered
➤ MENTAL HEALTH AND ALCOHOL AND SUBSTANCE USE SERVICES	PARTICIPATING PROVIDER
<ul style="list-style-type: none"> <li><b>Mental Health Care</b> <ul style="list-style-type: none"> <li>Inpatient</li> <li>Outpatient</li> </ul> </li> </ul>	<p>\$2,000 Copayment , Unlimited Days</p> <p>\$30 Copayment, Unlimited Visits Outpatient Mental Health; Outpatient Mental Health, Other \$0 Copay</p>
<ul style="list-style-type: none"> <li><b>Substance Use Services</b> <ul style="list-style-type: none"> <li>Inpatient</li> <li>Outpatient</li> </ul> </li> </ul>	<p>\$2,000 Copayment, Unlimited Days</p> <p>\$30 Copayment, Unlimited Visits; Other, \$0 Copay</p>
➤ SPECIAL KINDS OF CARE	PARTICIPATING PROVIDER
<b>Urgent Care Center</b>	\$30 Copayment
<b>Non-Emergency Ambulance Services</b>	Covered in full
<b>Pre-Hospital Emergency Medical Services (Ambulance Services)</b>	Covered in full



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➤ SPECIAL KINDS OF CARE	PARTICIPATING PROVIDER
Home health care	\$50 Copayment; 40 visits
Hospice care	Covered in full, 210 days
Skilled Nursing Facility (including cardiac and pulmonary rehabilitation)	Covered in full, 30 Day Limit
Dialysis treatment <ul style="list-style-type: none"> <li>• Performed in PCP Office</li> <li>• Performed in Specialist Office</li> <li>• Performed in Free Standing Center</li> <li>• Performed as Outpatient Hospital Services</li> </ul>	\$30 Copayment \$30 Copayment \$30 Copayment \$30 Copayment
Diabetes equipment, supplies, Insulin and education	\$30 Copayment/ Insulin \$0 Copayment
Chiropractic Services	\$75 Copayment
Family Planning Services	Covered
Vasectomy	\$75 Copayment
Infertility Diagnosis and Treatment	3 Cycles IVF, Per Lifetime, Subject To Applicable Copayment
Dental Care <ul style="list-style-type: none"> <li>• Preventive Dental</li> </ul>	Preventive Not Included
Durable Medical Equipment and Braces	Not Covered
Prosthetics	Not Covered
Orthotics	Not Covered
Medical Supplies	Covered in full
External Hearing Aids	Not Covered
Cochlear Implants	No Copayment - One (1) per ear per time Covered
Optical Care <ul style="list-style-type: none"> <li>• Refractive Eye Exams</li> <li>• Eyeglasses</li> </ul>	\$50 Copayment / Once per covered period Eyeglasses \$35 Every 24 Months
ABA Treatment for Autism Spectrum Disorder	\$30 Copayment
Assistive Communication Devices for Autism Spectrum Disorder	\$30 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*