EmblemHealth

POS SUMMARY OF BENEFITS

➢ DEDUCTIBLES	➢ COINSURANCE	➢ COINSURANCE MAXIMUM	➢ ANNUAL MAXIMUM BENEFIT
In-Network: $0	**In-Network:** Member pays 0%	**In-Network:** Not applicable	**In-Network:** Unlimited
Out-of-Network Individual $250 / Family $500	**Out-of-Network** Member pays 20%	**Out-of-Network** Individual $2,000/Family $4,000	**Out-of-Network** Unlimited

➢ MAJOR COPAYMENT PROVISIONS (IN-NETWORK)	COPAYMENT
PCP Office Visits	No copay
Specialist Office Visits	No copay
Hospital admission	
Emergency Room copay (waived if admitted)	$10 generic / $20 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.)
Prescription drugs	

➢ INPATIENT HOSPITAL SERVICES	IN-NETWORK *(Total day/visit limits include those received from Participating and/or Non-Participating Providers)*	OUT-OF-NETWORK *(Total day/visit limits include those received from Participating and/or Non-Participating Providers)*
• Semi-private room and board	No copay	Subject to Deductible and Coinsurance
• Operating and recovery room, intensive and special care units, general nursing care, staff physician services, prescribed drugs, anesthesia, x-rays and lab tests	No copay	Subject to Deductible and Coinsurance
• Short-term speech, physical, occupational and respiratory therapy (when part of an acute admission)	No copay Short-term only	Subject to Deductible and Coinsurance
• Speech, physical, occupational and respiratory therapy (when part of a rehabilitation admission)	No copay 90 days per calendar year	Subject to Deductible and Coinsurance
• Radiation therapy and chemotherapy	No copay	Subject to Deductible and Coinsurance
• Pre-admission testing	No copay	Subject to Deductible and Coinsurance
• Surgeon & Specialist services	No copay	Subject to Deductible and Coinsurance
• Human organ transplants	No copay	Subject to Deductible and Coinsurance

➢ OUTPATIENT MEDICAL CARE	IN-NETWORK *(Total day/visit limits include those received from Participating and/or Non-Participating Providers)*	OUT-OF-NETWORK *(Total day/visit limits include those received from Participating and/or Non-Participating Providers)*
• PCP office visits	Subject to PCP office visit copay	Subject to Deductible and Coinsurance
• Specialists office visits	Subject to Specialist office visit copay	Subject to Deductible and Coinsurance

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• Preventive care, including physical exams, health education and counseling, immunizations and associated diagnostic services	$0 Copay	Subject to Deductible and Coinsurance
• Well-woman care, including pap smears and mammography	$0 Copay	Subject to Deductible and Coinsurance
• Well-child care	$0 copay	Subject to Deductible and Coinsurance
• Diagnostic services including X-ray, lab tests, EKG's	Included in PCP office visit copay	Subject to Deductible and Coinsurance when related to illness or injury
• Prenatal, postnatal care in physician's office	$0 copay	Subject to Deductible and Coinsurance
• Ambulatory surgery		Subject to Deductible and Coinsurance
• Second medical and surgical opinion	$0 copay	Subject to Deductible and Coinsurance
• Routine Foot Care	Not covered	Not covered
• Chiropractic Services	Subject to Specialist office visit copay	Subject to Deductible and Coinsurance

➢ **MENTAL HEALTH AND SUBSTANCE USE DISORDER**	**IN-NETWORK** *(Total day/visit limits include those received from Participating and/or Non-Participating Providers)*	**OUT-OF-NETWORK** *(Total day/visit limits include those received from Participating and/or Non-Participating Providers)*
Mental Health Care		
• **Inpatient**		
- Treatment of Mental Illness	No copay; Unlimited days per calendar year	Subject to Deductible and Coinsurance
• **Outpatient**		
- Treatment of Mental Illness	$0 copay Unlimited Visits per calendar year	Subject to Deductible and Coinsurance
Substance Use Disorder		
• Inpatient Detoxification	No copay no limit on days per calendar year	Subject to Deductible and Coinsurance
• Inpatient rehabilitation treatment	No copay unlimited days per calendar year	Subject to Deductible and Coinsurance
• Outpatient rehabilitation treatment	No copay, Unlimited Visit - per calendar year	Subject to Deductible and Coinsurance

➢ **SPECIAL KINDS OF CARE**	**IN-NETWORK** *(Total day/visit limits include those received from Participating and/or Non-Participating Providers)*	**OUT-OF-NETWORK** *(Total day/visit limits include those received from Participating and/or Non-Participating Providers)*
Emergency and urgent care		
• In hospital emergency room	Subject to Emergency Room copay	Same as In-Network Coverage
• In urgent care facility	Subject to PCP or Specialist office visit copay	Subject to Deductible and Coinsurance
• In physicians office	Subject to PCP or Specialist office visit copay	Subject to Deductible and Coinsurance

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• Ambulance service to hospital	$0 copay	Subject to Deductible and Coinsurance
Home health care	No copay; 200 visits per calendar year	Subject to Deductible and Coinsurance
Hospice care	$0 copay; 210 days	Not covered Out-of-Network
Skilled Nursing Facility care	$0 copay; Unlimited days per calendar year	Not covered Out-of-Network
Dialysis treatment	$10 copay per visit	Subject to Deductible and Coinsurance
Diabetes equipment, supplies and education		Subject to Deductible and Coinsurance
Outpatient physical, speech, occupational and respiratory therapy	Subject to Specialist office visit copay; 90 visits per calendar year	Subject to Deductible and Coinsurance
Family Planning Services	Covered	Subject to Deductible and Coinsurance
Infertility Diagnosis and Treatment	Subject to applicable copays	Subject to Deductible and Coinsurance
In-vitro Fertilization		Subject to Deductible and Coinsurance
Dental Care		
• General Dental Care	Covered at reduced member fee schedule	Not covered Out-of-Network
• 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	Not covered Out-of-Network
Durable Medical Equipment	$50 annual deductible	Not covered Out-of-Network
Private Duty Nursing	After the first 72 hours, covered 80% up to 504 hours	Not covered Out-of-Network
Hearing Aids	Not covered; Cochlear implants covered	Not covered
Optical Care		
• Refractive Eye Exams		Subject to Deductible and Coinsurance
• Eyeglasses	$45 for a complete pair every 24 months	Not covered Out-of-Network
➢ ADDITIONAL BENEFITS	**IN-NETWORK** *(Total day/visit limits include those received from Participating and/or Non-Participating Providers)*	**OUT-OF-NETWORK** *(Total day/visit limits include those received from Participating and/or Non-Participating Providers)*
• Nurse Advice Line	Not Covered	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.
We determine the allowed amount paid for covered services received from health care providers not in our network of participating providers. This allowed amount is the FAIR Health HCPCS fee schedule at the 80th percentile.
HIP Health Plan of New York (HIP) and HIP Insurance Company of New York are EmblemHealth companies.