



SUMMARY OF BENEFITS

Prime HMO

HIP Prime Network for NY CT and NJ Residents

THE SEGAL COMPANY NON UNION

1102161

➤ 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	\$25 Copayment
Specialist Office visits	\$40 Copayment
Hospital admission	\$500 Copayment
Emergency Room copay (waived if Hospital admission)	\$100 Copayment
Prescription Drug Deductible	\$50 deductible applies
Prescription drugs – 30 day supply	\$15 generic / \$30 brand / \$50 non-formulary
Prescription drugs – 90 day supply	\$22.50 generic / \$45 brand / \$75 non-formulary
➤ INPATIENT HOSPITAL SERVICES	PARTICIPATING PROVIDER
<ul style="list-style-type: none"> Hospital and physician services 	Subject to Hospital Admission Copayment Physician Services Covered in Full
<ul style="list-style-type: none"> Semi-private room and board 	Included in Hospital Admission Copayment
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Inpatient Habilitation Services (Physical, Speech and Occupational Therapy), 30 days of combined therapies 	\$500 Copayment
<ul style="list-style-type: none"> Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy), 30 days of combined therapies 	\$500 Copayment
<ul style="list-style-type: none"> Human organ transplants 	Included in Hospital Admission Copayment
➤ MATERNITY AND NEW BORN CARE	PARTICIPATING PROVIDER
<ul style="list-style-type: none"> Prenatal care 	Covered in full
<ul style="list-style-type: none"> Inpatient Hospital Services and Birthing Center 	\$500 Copayment
<ul style="list-style-type: none"> Physician and Midwife Services for Delivery 	Covered In Full
<ul style="list-style-type: none"> Breast Pump 	Covered in full
<ul style="list-style-type: none"> 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	\$40 Copayment ; 32 visits, combined with Specialist Office limits
• Performed in a Specialist Office	\$40 Copayment ; 32 visits, combined with Outpatient Hospital limits
➤ OUTPATIENT MEDICAL CARE	PARTICIPATING PROVIDER
• PCP office visits	\$25 Copayment
• Specialists office visits	\$40 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
<ul style="list-style-type: none"> • Laboratory Procedures, <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in Specialist Office • Performed in a Free Standing Laboratory • Performed as Outpatient Hospital Services 	<ul style="list-style-type: none"> Covered in full Covered in full Covered in full Covered in full
<ul style="list-style-type: none"> • Diagnostic Radiology <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in Specialist Office • Performed in a Free Standing Radiology Facility • Performed as Outpatient Hospital Services 	<ul style="list-style-type: none"> Covered in full Covered in full Covered in full Covered in full
<ul style="list-style-type: none"> • Diagnostic Testing <ul style="list-style-type: none"> • Performed in a PCP Office 	Covered in full



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➤ OUTPATIENT MEDICAL CARE	PARTICIPATING PROVIDER
<ul style="list-style-type: none"> • Performed in Specialist Office • Performed as Outpatient Hospital Services 	<p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p>
<ul style="list-style-type: none"> • Advanced Imaging Services (PET scans, MRI, nuclear medicine, CAT scans) <ul style="list-style-type: none"> • Performed in a Specialist Office • Performed in a Free Standing Radiology Facility • Performed as Outpatient Hospital Services 	<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"> • Infusion Therapy <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office Referral required • Performed as Outpatient Hospital Services • Home Infusion Therapy 	<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"> • Ambulatory surgery center facility 	<p style="text-align: center;">\$100 Copayment</p>
<ul style="list-style-type: none"> • Outpatient hospital surgery facility 	<p style="text-align: center;">\$100 Copayment</p>
<ul style="list-style-type: none"> • Preadmission testing 	<p style="text-align: center;">Covered in full</p>
<ul style="list-style-type: none"> • Second opinions on the diagnosis of cancer, surgery and other 	<p style="text-align: center;">Covered in full</p>
<ul style="list-style-type: none"> • Outpatient Habilitation Services <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services 	<p style="text-align: center;">60 visits, combined therapies</p> <p style="text-align: center;">\$25 Copayment</p> <p style="text-align: center;">\$40 Copayment</p> <p style="text-align: center;">\$40 Copayment</p>
<ul style="list-style-type: none"> • Radiation therapy <ul style="list-style-type: none"> • Performed in a Specialist Office • Performed in a Free Standing Radiology Facility • Performed as Outpatient Hospital Services 	<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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➤ OUTPATIENT MEDICAL CARE	PARTICIPATING PROVIDER
<ul style="list-style-type: none"> Chemotherapy <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>
<ul style="list-style-type: none"> Outpatient Rehabilitation Services(physical therapy,occupational therapy, speech therapy, pulmonary rehabilitation) <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>60 visits, combined therapies</p> <p>\$25 Copayment</p> <p>\$40 Copayment</p> <p>\$40 Copayment</p>
<ul style="list-style-type: none"> Allergy Testing and Treatment <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	<p>\$25 Copayment</p> <p>\$40 Copayment</p>
<ul style="list-style-type: none"> Acupuncture 	Not Covered
<ul style="list-style-type: none"> Telemedicine Program Provided by a Telemedicine Physician 	Not Covered
➤ MENTAL HEALTH AND ALCOHOL AND SUBSTANCE USE SERVICES	PARTICIPATING PROVIDER
<ul style="list-style-type: none"> Mental Health Care <ul style="list-style-type: none"> Inpatient Outpatient 	<p>\$500 Copayment , Unlimited Days</p> <p>\$25 Copayment, Unlimited Visits</p>
<ul style="list-style-type: none"> Substance Use Services <ul style="list-style-type: none"> Inpatient Outpatient 	<p>\$500 Copayment, Unlimited Days</p> <p>\$25 Copayment</p>
➤ SPECIAL KINDS OF CARE	PARTICIPATING PROVIDER
Urgent Care Center	\$25 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 <ul style="list-style-type: none"> • Performed in PCP Office • Performed in Specialist Office • Performed in Free Standing Center • Performed as Outpatient Hospital Services 	\$25 Copayment \$25 Copayment \$25 Copayment \$25 Copayment
Diabetes equipment, supplies, Insulin and education	\$25 Copayment
Chiropractic Services	\$40 Copayment
Family Planning Services	Covered
Vasectomy	\$40 Copayment
Infertility Diagnosis and Treatment	3 Cycles IVF, Per Lifetime, Subject To Applicable Copayment
Dental Care <ul style="list-style-type: none"> • Preventive Dental 	Preventive Included
Durable Medical Equipment and Braces	\$100 Deductible, Covered In Full
Prosthetics	\$100 Deductible, Covered In Full
Orthotics	\$100 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 <ul style="list-style-type: none"> • Refractive Eye Exams • Eyeglasses 	Covered in full / Once per covered period 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 out-of-network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge. Some Covered Services, such as Acupuncture, Urgent Care, Telemedicine, and Prescription Drugs are only Covered when received from Participating Providers and are not Covered as out-of-network benefits.

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.