EmblemHealth®

HIP Prime HMO 2024 Summary of Benefits

SERVICE CATEGORY	COVERAGE	COPAY
Physician Services	**Primary Care Provider (PCP) Office Visits**	
	Adults	$5 per visit
	Sick-Child Visits (Age 0-25)	$5 per visit
	Laboratory Services	$5 per visit
	X-ray Services	$5 per visit
	Specialist Office Visits	
	Office Visits	$10 per visit
	Laboratory Services	$10 per visit
	Refractive Eye Exams	$0
	X-ray Services	$10 per visit
	Inpatient Hospital Services	
	Anesthesiology	$0
	Radiology Visits/Consultations	$0
Preventive & Wellness Care Services*	Well-Baby, Child Care, and Immunizations	$0
	Adult Physical	$0
	Mammography & Prostate Cancer Screening	$0
	Annual Pap Test & OB/GYN Exam	$0
	Immunizations for Adults	$0
	Colonoscopy & Sigmoidoscopy Screening for Adults	$0
	Bone Density Tests	$0
Hospital	Hospital Inpatient	$0 per continuous stay
	Hospital Outpatient Surgery	$0
	Hospital Outpatient X-ray	$0
	Hospital Outpatient Laboratory	$0
Maternity	Physician Services	$0
	Hospital Services	$0
	Nursery Care	$0
Emergency Room (ER) Visit		$75 per visit
Ambulance		$0
Chiropractic Benefit		$10 per visit
Durable Medical Equipment		$0
Mental Health	Inpatient	$0
	Outpatient	$0
Substance Abuse Diagnosis & Treatment	Inpatient	$0
	Rehabilitation Outpatient:	
	• Primary Care Provider Office	$5 per visit
	• Specialist Office	$5 per visit
Physical/Occupational/Speech Therapy	Outpatient Facility	$0; Combined 90 visits per calendar year
	Primary Care Provider Office	$5 per visit

(Continued)

*Preventive services are covered in full only when provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (ACIP), or when required by New York state law.

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SERVICE CATEGORY	COVERAGE	COPAY
Home Health Care		$0 – 200 visits per calendar year
Lifetime Maximum Coverage		Not applicable
Additional Benefits		
Autism Spectrum Disorder	Inpatient Outpatient: • Primary Care Provider (PCP) Office • Specialist Office Assistive Communication Devices	$0 $5 per visit $5 per visit Covered in full
Diabetic Supplies		$5 per 34-day supply
Dialysis Treatment	Primary Care Provider (PCP) Office Freestanding Center Outpatient Hospital	$5 per visit $0 $0
Hospice Care		$0 – 210 days per lifetime
Skilled Nursing Facility Care		$0
Urgent Care		$25 per visit
Out-of-Pocket Maximum (per calendar year): $6,850 per individual and $13,700 per family		

Except for emergency care, the above benefits and services are covered only when provided or referred by a HIP primary care provider (PCP) and/or approved in advance by our Utilization Management Department. 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 it does not constitute an Agreement.