EmblemHealth
WHAT CARE FEELS LIKE.

# SUMMARY OF BENEFITS — EMBLEMHEALTH HEALTHY NY PLAN

| | COMMENTS/LIMITATIONS | IN-NETWORK |
|---|---|---|
| **BENEFIT HIGHLIGHTS** | | |
| Primary Care Physician Office Visit | | $25 copay after deductible |
| Specialist Office Visit | Referral needed from member's PCP | $40 copay after deductible |
| Emergency Room Facility | Copay waived if admitted to hospital | $150 copay after deductible |
| Urgent Care Facility | In-Network coverage only | $60 copay after deductible |
| Ambulatory Surgery Facility | | $100 copay after deductible |
| Coinsurance | See below for applicable services | 20% |
| Annual Deductible (Individual/Family) | Applies to hospital and medical | $600 / $1,200 |
| Annual Out-of-Pocket Maximum (Individual/Family) | See footnotes* | $4,000 / $8,000 |
| **INPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL** | | |
| Inpatient Hospital Admission | 365 days per calendar year | $1,000 copay per admission after deductible |
| Skilled Nursing Facility Care | 200 days per calendar year | $1,000 copay per admission after deductible |
| Inpatient Rehabilitation | One consecutive 60-day period, per condition, per lifetime | $1,000 copay per admission after deductible |
| Hospice Care | 210 days | $1,000 copay per admission after deductible |
| **OUTPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL OR FACILITY** | | |
| Pre-admission Testing | | Covered in full |
| Ambulatory Surgery Facility (Freestanding and outpatient hospital) | | $100 copay after deductible |
| Home Health Care Services | 40 visits per person, per calendar year | $25 copay after deductible |
| Diagnostic Laboratory and Radiology | Advanced radiology requires prior approval | $40 copay after deductible |
| Chemotherapy | | $25 copay after deductible |
| **MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN OR OTHER MEDICAL PROVIDER** | | |
| Primary Care Physician Office Visit | | $25 copay after deductible |
| Specialist Office Visit | Referral needed from member's PCP | $40 copay after deductible |
| Maternity Pre- and Postnatal Care | | Covered in full |
| Chiropractic Care | | $40 copay after deductible |
| Allergy Care | Copay amount is determined by type of provider visited for service | $25 PCP Copay / $40 Specialist Copay after deductible |
| Physical, Occupational, and Speech Therapy Rehabilitative and Habilitative | Combined 60 visits, per condition, per lifetime | $30 copay after deductible |
| Surgery: Inpatient/Outpatient | | $100 copay after deductible |
| Surgery: Office | | $40 copay after deductible |
| Pediatric Vision - Exams | One exam per 12 month period. Coverage up to age 19 end of month | $25 copay |
| Pediatric Vision - Lenses & Frames | One set of lenses & frames or contacts per 12 month period. Coverage up to age 19 end of month | 20% coinsurance |
| Diagnostic Laboratory and Radiology | Copay amount is determined by type of provider visited for service. Advanced radiology requires prior approval | $25 PCP Copay / $40 Specialist Copay after deductible |

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| **MEDICAL SUPPLIES/DEVICES/DME** | | |
| Durable Medical Equipment (DME) | Standard equipment only; excludes orthotics | 20% coinsurance after deductible |
| Hearing Aids | Single purchase, one or both ears, (including repair/replacement) every three years. | 20% coinsurance after deductible |
| Prosthetic Devices-external | One device per limb, per lifetime | 20% coinsurance after deductible |
| **PREVENTIVE CARE** | | |
| Well-Baby and Well-Child Care, including Immunizations | | Covered in full |
| Annual Physical Checkup | | Covered in full |
| Preventive Mammography, Pap Smear, Prostate and Bone Density Screening | | Covered in full |
| Colonoscopy Screenings | | Covered in full |
| **EMERGENCY COVERAGE** | | |
| Emergency Room Facility | Copay waived if admitted to hospital | $150 copay after deductible |
| Emergency Room Professional | | Covered in full |
| Ambulance | | $150 copay after deductible |
| **INPATIENT MENTAL HEALTH & SUBSTANCE USE** | | |
| Inpatient Mental Health | | $1,000 copay per admission after deductible |
| Inpatient Substance Use Services: Detoxification and Rehabilitation | | $1,000 copay per admission after deductible |
| **OUTPATIENT MENTAL HEALTH & SUBSTANCE USE** | | |
| Outpatient Mental Health | | $25 copay after deductible |
| Outpatient Substance Use Services | Includes 20 family counseling visits | $25 copay after deductible |
| **PRESCRIPTIONS DRUGS** | | |
| Retail | 30-day supply | $10 / $35 / $70 |
| Mail Order | 90-day supply | $25 / $88 / $175 |
| **EXERCISE FACILITY INCENTIVE** | | |
| Gym Reimbursement | Incentive only available to Subscriber and Subscriber's Covered Spouse. Incentive is not applied to Out Of Pocket Maximum or Deductible | Subscriber reimbursed up to $200 for completion of 50 exercise facility visits in each six month period. Covered Spouse reimbursed up to $100 per six-month period and 50 exercise facility visits. |

The EmblemHealth Healthy NY Plan is underwritten by HIP Health Plan of New York. Except for emergency care, the above benefits and services are covered only when provided or referred by a Select Care network primary care physician and/or approved in advance by the EmblemHealth Care Management Program. Participating physicians and providers have contracted with EmblemHealth 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 or limitations of the Plan which are available only in the Contract or Certificate of Coverage, and it does not constitute an agreement. Refer to HIP policy form number 155-23-SGOFFHIXHNYCERT (04/13), et al.

Certain services must be approved in advance by EmblemHealth.

*Out Of Pocket max incudes deductible, copays and coinsurance. Gym Reimbursement benefit does not apply towards the OOP max.