EmblemHealth

POS SUMMARY OF BENEFITS

HIP Prime Network

HOFSTRA UNIVERSITY

➢ 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 30%	**Out-of-Network** Individual $5,000/Family $10,000	**Out-of-Network** Unlimited

➢ MAJOR COPAYMENT PROVISIONS (IN-NETWORK)	COPAYMENT
PCP Office Visits	$15 copay per visit
Specialist Office Visits	$15 copay per visit
Hospital admission	No copay
Emergency Room copay (waived if admitted)	$50 copay per visit
Prescription drugs	$10 generic / $15 brand (Subject to Drug Formulary) Contraceptives Included; $30 Non-Formulary(Formulary copays are reduced by 50% when utilizing the HIP Mail Order Pharmacy Service. Up to a 90 day supply may be obtained.)

➢ 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 30 days per plan 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)*

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• 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
• 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	No copay	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 plan year	Subject to Deductible and Coinsurance
• **Outpatient**		
- Treatment of Mental Illness	$15 copay Unlimited Visits per plan year	Subject to Deductible and Coinsurance
Substance Use Disorder		
• Inpatient Detoxification	No copay No limit on days per plan year	Subject to Deductible and Coinsurance
• Inpatient rehabilitation treatment	No copay Unlimited days per plan year	Subject to Deductible and Coinsurance

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• Outpatient rehabilitation treatment	$15 Copay per visit, Unlimited Visit - per plan 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 office visit copay	Subject to Deductible and Coinsurance
• In physicians office	Subject to PCP or Specialist office visit copay	Subject to Deductible and Coinsurance
• Ambulance service to hospital	$0 copay	Subject to Deductible and Coinsurance
Home health care	$15 copay; 40 visits per plan year	Subject to Deductible and Coinsurance
Hospice care	$0 copay; 210 days	Not covered Out-of-Network
Skilled Nursing Facility care	$0 copay; 45 days per plan year	Not covered Out-of-Network
Dialysis treatment	$15 copay per visit	Subject to Deductible and Coinsurance
Diabetes equipment, supplies and education	$15 copay per month	Subject to Deductible and Coinsurance
Outpatient physical, speech, occupational and respiratory therapy	Subject to Specialist office visit copay; 120 visits per plan 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	IVF 3 Cycle limit per lifetime, subject to applicable copay	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	$0 annual deductible	Not covered Out-of-Network
Private Duty Nursing	Covered in full	Not covered Out-of-Network
Hearing Aids	Not covered; Cochlear implants covered	Not covered
Optical Care		
• Refractive Eye Exams	$15 copay	Subject to Deductible and Coinsurance

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• Eyeglasses	Every 24 months:$80 frame allowance;$35 co-pay for lenses	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
• Telemedicine		Not Covered

FOOTNOTES

Drugs are dispensed in accordance with HIP's Drug Formulary. Please refer to your Prescription Drug Rider for details.
** When you need specialty care, your PCP will refer you to a specialist in your network. Your PCP or specialist will also contact us to get any necessary approvals. Referrals and prior approvals are only valid for the specialist or hospital named on the referral, and for a specific number of visits and length of time.*
You must obtain prior approval from EmblemHealth if you will receive any of the following services from an out-of-network provider: hospital or facility inpatient admissions, ambulatory surgery services, home health care services. Failure to obtain prior approval when required will result in a 50% reduction of the benefit otherwise payable.
Certain services are only available in network, such as skilled nursing facility, hospice care services and durable medical equipment. Please refer to your Certificate of Coverage for details and a complete listing of covered services. If you have any questions call the Customer Service number on the back of your ID card.
***Maximum Out-of-Pocket means the maximum amount of Copayments, Coinsurance and Deductible expenses that You must pay in a coverage period (Calendar Year or Contract Year) for essential health benefits covered services received from Participating Providers.*
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.
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.
HIP Health Plan of New York (HIP) and HIP Insurance Company of New York are EmblemHealth companies.

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