EmblemHealth®

HIP Prime (HMO) 2025 Summary of Benefits

SERVICE CATEGORY	COVERAGE	COPAY
Physician Services	**Primary Care Provider 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
	Inpatient Hospital Services	
	Anesthesiology	$0
	Radiology visits/consultations	$0
Preventive and Wellness Care Services*	Well-baby, child care, and immunizations	$0
	Adult physical	$0
	Mammography and prostate cancer screening	$0
	Annual pap test and OB/GYN exam	$0
	Immunizations for adults	$0
	Colonoscopy and 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 Use Diagnosis and Treatment	Inpatient	$0
	Rehabilitation outpatient:	
	• Primary care provider office	$0 per visit
	• Specialist office	$0 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); if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF); 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 office • Specialist office Assistive communication devices	$0 $5 per visit $5 per visit $0 per visit
Diabetic Supplies		$5 per 34-day supply
Dialysis Treatment	Primary care provider 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 physician 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.