HIP PRIME POS

Members have access to top quality health care providers through HIP's alliances with outstanding medical groups and hospitals, including Montefiore Medical Center, Lenox Hill Hospital, St. Barnabas Hospital, St. Luke's Roosevelt Hospital and Beth Israel Medical Center.

HIP Prime POS is a point-of-service plan offering both in- and out-of-network coverage. Members can go to virtually any doctor or specialist at any location and still take advantage of HIP's value. Non-referred and out-of-network services are subject to deductibles and coinsurance.

At a Glance	
Plan Type:	POS
Geographic Service Area	HIP's service area includes Bronx, Kings, Manhattan, Queens, Richmond, Rockland, Nassau, Suffolk, Westchester, Broome, Otsego, Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington, Delaware, Dutchess, Orange, Putnam, Sullivan and Ulster counties.
Does this plan use a network of providers?	Yes. Visit the Web site www.emblemhealth.com/city or call 1-800-447-8255
Do I need a referral to see a specialist?	Yes, written approval is required to see a specialist.
Contact Information	EmblemHealth HIP 55 Water Street New York, NY 10041 1-800-447-8255. Representatives will be available Monday through Friday, 8:00 a.m. to 8:00 p.m. to answer your questions.
Web Site	Emblemhealth.com/city

Plan Features	Cost
What is the overall deductible for this plan?	• $750 for out-of-network provider per person/$2,250 family
What are the costs when you visit a health care provider's office or clinic?	• Primary care visit to treat an injury or illness: • In-network: $10 co-pay • Out of network: After the deductible is met 30% coinsurance • Specialist visit: • In-network $15 co-pay • Out of network: After the deductible is met 30% coinsurance • Other practitioner office visit Chiropractor: • In-network: $15 co-pay • Out of network: After the deductible is met 30% coinsurance • Preventive care/screening/immunization: • In-network: No charge • Out of network: After the deductible is met 30% coinsurance
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): In-network: No charge Out of network: After the deductible is met 30% coinsurance Imaging (CT/PET scans, MRIs): In-network: No charge Out of network: After the deductible is met 30% coinsurance Prior approval required
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): $100 co-pay 30% co-insurance for non-participating provider Prior approval required Physician/surgeon fees: No charge 30% co-insurance for non-participating provider Prior approval required

What are the costs if you need immediate medical attention?	Emergency room services: $100 co-pay/visit $100 co-pay to non-participating provider Waived if admitted Emergency medical transportation: No charge No charge to non-participating provider Urgent Care: In-network: $10 co-pay/visit Out of network: After the deductible is met 30% coinsurance
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): $100 per continuous stay 30% co-insurance for non-participating provider Prior approval required Physician/surgeon fee: No charge 30% co-insurance for non-participating provider
What are the costs if you are pregnant?	Prenatal and postnatal care: In-network: No charge Out of network: After the deductible is met 30% coinsurance Delivery and all inpatient services: In-network: $100 per continuous stay Out of network: After the deductible is met 30% coinsurance Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Prior approval required.

WHAT ARE THE COSTS IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS?

Service	Cost
Mental/Behavioral health Outpatient services	• In-network: $10 co-pay/visit • Out of network: After the deductible is met 30% coinsurance
Mental/Behavioral health Inpatient services	• In-network: $100 per continuous stay • Out of network: After the deductible is met 30% coinsurance • Prior approval required
Substance abuse Outpatient services	• In-network: $10 co-pay/visit • Out of network: After the deductible is met 30% coinsurance
Substance abuse Inpatient services	• In-network: $100 per continuous stay • Out of network: After the deductible is met 30% co-insurance • Prior approval required

What are the costs if you need help recovering or have other special health needs?

Service	Cost
Home health care	• In-network: No charge • Out of network: After the deductible is met 30% co-insurance • Coverage limited to 200 visits per year for both in and out of network combined. • Prior approval required
Rehabilitation services Inpatient	• In-network: $100 per continuous confinement • Out of network: After the deductible is met 30% co-insurance • Limited to 90 visits per year for both in and out of network combined • Prior approval required
Rehabilitation services Outpatient	• In-network: $15 co-pay/visit • Out of network: After the deductible is met 30% co-insurance • Limited to 90 visits per year for both in and out of network combined • Prior approval required
Habilitation services Inpatient	• In-network: $100 per continuous confinement • Out of network: After the deductible is met 30% co-insurance • Limited to 90 visits per year for both in and out of network combined • Prior approval required
Habilitation services Outpatient	• In-network: 15 co-pay/visit • Out of network: After the deductible is met 30% co-insurance • Limited to 90 visits per year for both in and out of network combined

	• Prior approval required
Skilled nursing care	• In-network: No charge • Not covered for non-participating provider • Prior approval required
Durable medical equipment (DME)	• In-network: No charge • Not covered for non-participating provider • Prior approval required
Hospice service	• In-network: No charge • Not covered for non-participating provider • Limited to 210 days

OPTIONAL RIDER

WHAT IS THE COST IF YOU NEED DRUGS TO TREAT YOUR ILLNESS OR CONDITION?

		Retail	Mail Order
Generic drugs*		$10 co-pay/30 day supply	$15 copay/90 day supply
Preferred brand drugs*		$35 co-pay/30 day supply	$52.50 co-pay/90 day supply
Non-preferred brand drugs		Not covered	Not covered
Specialty drugs**	Generic drugs	$10 co-pay/30 day supply	$15 co-pay/90 day supply
	Preferred brand drugs	$35 co-pay/30 day supply	$52.50 co-pay/90 day supply
	Non-preferred brand drugs	Not covered	

*Must be dispensed by a Participating Pharmacy.

**Must be dispensed by a Specialty Pharmacy. Written referral required.

Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.