

HIP PRIME HMO



HIP Health Plan of New York was created more than 57 years ago to provide city workers and union members with high quality, affordable health insurance. Today, HIP remains committed to offering City employees and retirees a full range of coverage for medical and hospital services. 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 HMO offers members choice, convenience and access to quality health care. You and each member of your family choose a primary care physician (PCP) practicing in his/her private or group office or at any of the health care centers throughout HIP's service area.

At a Glance	
Plan Type:	HMO
Geographic Service Area	HIP's service area includes the five boroughs of New York City as well as Nassau, Suffolk, Rockland and Westchester counties.
Does this plan use a network of providers?	Yes. Visit the Web site or call 1-800-447-8255 for a list of participating providers.
Do I need a referral to see a specialist?	Yes, written approval is required to see a specialist.
Contact Information	HIP 55 Water Street New York, NY 10041 1-800-447-8255 Representatives will be available Monday through Friday, 8:00 a.m. to 6:00 p.m. to answer your questions.
Web Site	Emblemhealth.com/city

Plan Features	Cost
What is the overall deductible for this plan?	• \$0
What are the costs when you visit a health care provider's office or clinic?	Primary care visit to treat an injury or illness: Preferred \$0 co-pay/visit Participating \$10 co-pay/visit Not covered for non-participating provider Specialist visit: Preferred \$0 co-pay/visit Participating \$10 co-pay/visit Not covered for non-participating provider Other practitioner office visit Chiropractor: Preferred \$0 co-pay/visit Participating \$10 co-pay/visit Not covered for non-participating provider Preventive care/screening/immunization: Preferred \$0 co-pay/visit Participating \$0 co-pay/visit Not covered for non-participating provider
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): Preferred \$0 co-pay/visit Participating \$10 co-pay/visit Imaging (CT/PET scans, MRIs): Preferred \$0 co-pay/visit Participating \$10 co-pay/visit
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): \$50 co-pay Not covered for non-participating provider Prior approval required Physician/surgeon fees: No charge Not covered for non-participating provider Prior approval required
What are the costs if you need immediate medical attention?	Emergency room services: \$50 co-pay/visit \$50 co-pay to non-participating provider Emergency medical transportation: No charge No charge to non-participating provider Urgent Care: Preferred \$0 co-pay/visit

Participating \$10 co-pay/visit	
What are the costs if you have a hospital stay?	<p>Facility fee (e.g., hospital room): \$100 per continuous stay Not covered for non-participating provider</p> <p>Prior approval required</p> <p>Physician/surgeon fee: No charge Not covered for non-participating provider</p>
What are the costs if you are pregnant?	<p>Prenatal and postnatal care: No charge Not covered for non-participating provider</p> <p>Delivery and all inpatient services: \$100 per continuous stay Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Prior approval required.</p>

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

Service	Cost
Mental/Behavioral health Outpatient services	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider • Prior approval may be required
Mental/Behavioral health Inpatient services	<ul style="list-style-type: none"> • \$100 per continuous stay • Not covered for non-participating provider • Prior approval required
Substance abuse Outpatient services	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider • Prior approval required • Certain services may not be covered, see plan documents for details
Substance abuse Inpatient services	<ul style="list-style-type: none"> • \$100 per continuous stay • Not covered for non-participating provider • Prior approval required

WHAT ARE THE COSTS IF YOU NEED HELP RECOVERING OR HAVE OTHER SPECIAL HEALTH NEEDS?

Service	Cost
Home health care	<ul style="list-style-type: none"> • No charge • Coverage limited to 200 visits per year • Prior approval required
Rehabilitation services Inpatient	<ul style="list-style-type: none"> • \$100 per continuous confinement • Not covered for non-participating provider • Limited to 90 visits per year
Rehabilitation services Outpatient	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider • Limited to 90 visits per year
Habilitation services Inpatient	<ul style="list-style-type: none"> • \$100 per continuous confinement • Not covered for non-participating provider • Limited to 90 visits per year
Habilitation services Outpatient	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider • Limited to 90 visits per year • Limited to Autism services
Skilled nursing care	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider • Prior approval required
Durable medical equipment (DME)	<p>Not covered (with Optional Rider Only: No charge – Prior approval required)</p> <ul style="list-style-type: none"> • Not covered under Basic coverage (Only with Optional Rider: No charge- Prior approval required) • Not covered for non-participating provider

	<ul style="list-style-type: none"> • Prior approval required
Hospice service	<ul style="list-style-type: none"> • 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*	\$5 co-pay/30 day supply	\$7.50 copay/90 day supply
Preferred brand drugs	\$15 co-pay/30 day supply	\$22.50 co-pay/90 day supply
Non-preferred brand drugs	Not covered	Not covered
Specialty drugs**	Generic drugs	\$5 co-pay/30 day supply
	Preferred brand drugs	\$15 co-pay/30 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.