

HIP HMO PREFERRED



EmblemHealth was founded more than 60 years ago to provide city workers and union members high quality, affordable health insurance. It continues that tradition today, offering members choice, convenience, and access to a large regional network of health care professionals.

With the HIP HMO Preferred plan, there is a \$0 monthly premium for the base plan. There is also a \$0 copay for all preventative services. Members can visit the Hospital for Special Surgery (HSS), the nation’s top-ranked orthopedic hospital, and Memorial Sloan Kettering Cancer Center (MSK), one of the country’s leading cancer centers, through HMO Preferred’s new Centers of Excellence program.

To get started, members and their families must pick a primary care doctor (PCP). This is the doctor who gives everyday care. PCPs can refer members to health care professionals who treat certain health conditions. When members choose a preferred provider in the Prime network, they will be covered and pay less. All doctors in the AdvantageCare Physicians network are part of the preferred provider network.

At a Glance	
Plan Type:	HMO
Geographic Service Area	The Prime Network service area includes the tristate area, plus additional coverage in upstate New York.
Does this plan use a network of providers?	Yes. Visit emblemhealth.com/gold or call 833-CNY-GOLD (833-269-4653) (TTY:711) to learn more about our participating providers.
Do I need a referral to see a specialist?	Yes, written approval is required to see a specialist.
Contact Information	EmblemHealth 55 Water Street New York, NY 10041 833-CNY-GOLD (833-269-4653) (TTY:711) A Gold Line agent is available Monday through Friday, 8:00 a.m. to 8:00 p.m. and Saturdays 8 a.m. to 1 p.m. to answer your questions.
Web Site	Emblemhealth.com/gold

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 copay/visit Non-preferred \$10 copay/visit Not covered for non-participating provider Specialist visit: Members with a Preferred PCP \$0 copay/visit Members with a Non-preferred \$10 co-pay/visit Not covered for non-participating provider Other practitioner office visit Chiropractor: Members with a Preferred PCP \$0 copay/visit Members with a Non-Preferred PCP \$10 copay/visit Not covered for non-participating provider Preventive care/screening/immunization: Preferred \$0 copay/visit Non-preferred \$0 copay/visit Not covered for non-participating provider
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): Members with a Preferred PCP \$0 copay/visit Members with a Non-preferred PCP \$10 co-pay/visit Imaging (CT/PET scans, MRIs): Members with a Preferred PCP \$0 copay/visit Members with a Non-preferred PCP \$10 co-pay/visit
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): \$50 copay 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: \$150 copay/visit (waived if admitted) Emergency medical transportation: No charge Urgent Care: \$50 copay/visit
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): \$100 copay per continuous stay Not covered for non-participating provider Prior approval required Physician/surgeon fee included in hospital admission copay Not covered for non-participating provider
What are the costs if you are pregnant?	Prenatal and postnatal care: No charge Not covered for non-participating provider Delivery and all inpatient services: \$100 copay per continuous stay 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	<ul style="list-style-type: none"> Members with a Preferred PCP \$0 copay/visit Members with a Non-preferred PCP \$10 copay/visit Not covered for non-participating provider Prior approval may be required
Mental/Behavioral health Inpatient services	<ul style="list-style-type: none"> \$100 copay per continuous stay Not covered for non-participating provider Prior approval required
Substance abuse Outpatient services	<ul style="list-style-type: none"> Members with a Preferred PCP \$0 copay/visit Members with a Non-preferred PCP \$10 copay/visit 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 copay 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"> \$0 copay/visit Coverage limited to 200 visits per year Prior approval required
Rehabilitation services Inpatient	<ul style="list-style-type: none"> \$100 copay per continuous confinement Not covered for non-participating provider Limited to 90 visits per year
Rehabilitation services Outpatient	<ul style="list-style-type: none"> Members with a Preferred PCP \$0 copay/visit Members with a Non-preferred PCP \$10 copay/visit Not covered for non-participating provider Limited to 90 visits per year
Habilitation services Inpatient	<ul style="list-style-type: none"> \$100 copay per continuous confinement Not covered for non-participating provider Limited to 90 visits per year
Habilitation services Outpatient	<ul style="list-style-type: none"> Members with a Preferred PCP \$0 copay/visit Members with a Non-preferred PCP \$10 copay/visit

	<ul style="list-style-type: none"> • 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"> • \$0 copay unlimited days • Not covered for non-participating provider • Prior approval required
Durable medical equipment (DME)	<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 • Prior approval required
Hospice service	<ul style="list-style-type: none"> • \$0 copay/visit • 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 copay/30 day supply	\$7.50 copay/90 day supply
Preferred brand drugs	\$15 co-pay/30 day supply	\$22.50 copay/90 day supply
Non-preferred brand drugs	Not covered	Not covered
Specialty drugs**	Generic drugs	\$5 copay/30 day supply
	Preferred brand drugs	\$15 copay/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.