2016 EMBLEMHEALTH HMO DIRECT PAYMENT PLANS

EmblemHealth®
WHAT CARE FEELS LIKE.

EMBLEMHEALTH HMO DIRECT PAYMENT PLANS — A TRADITON OF SERVICE

For more than 75 years, EmblemHealth companies have offered quality, affordable health insurance to New Yorkers. It's what we do. By choosing an EmblemHealth HMO Direct Pay plan*, you have the opportunity to enroll in a plan designed to meet your health care needs.

EmblemHealth ensures each network physician is board-certified or board-eligible and demonstrates appropriate credentials. Our rigorous screening process helps ensure network quality standards.

How do I sign up?

Enrolling in an HMO Direct Pay plan is easy. Simply complete the enclosed HMO application and return it, along with payment, to EmblemHealth.

If you have any questions about these programs, our representatives can be reached at **1-888-290-9950**, seven days a week, 8:00 am to 8:00 pm. TTY/TDD users may call **711**.

*This brochure contains only general information. All plans are subject to the specific terms, conditions, exclusions and limitations of your contract.

The EmblemHealth Advantage

We know our members want quality, affordable health care coverage and we do our best to meet your needs. In 2016 we are offering the following plans: Select Care Platinum D, Select Care Gold D, Select Care Silver D and Select Care Bronze D. These plans cover the same benefits but with different cost-sharing.

Important to Know

- **PCP is Required** — You are required to select a Primary Care Physician (PCP) who participates in the Select Care provider network.
- **Referrals are Required** — You need a written referral from your PCP before receiving specialist care. Specialists are doctors who provide services other than primary care, such as allergists and dermatologists. You do not need a referral for chiropractic services; outpatient mental health services; refractive eye exams from an optometrist (this is only covered up to the end of the month in which you turn 19); diabetic eye exams from an ophthalmologist; and primary obstetric and gynecologic care.
- **In-Network Coverage** — with an EmblemHealth Direct Pay plan, you have in-network coverage only. Network doctors and other health care practitioners give you and your family access to a broad range of health services.
- **Preventive Services Covered in Full** — You can get preventive care services at no cost. Preventive care is covered in full and not subject to any deductible as long as you use a participating provider. These services include routine physicals, screening, immunizations, mammograms, gynecological exams, well-baby care and prescription contraceptives for women.
- **Prescription Drug Benefits Included** — Prescription drug coverage is included in these plans. You may request a copy of our drug formulary. Our drug formulary is also available on our website at **emblemhealth.com**. All prescription drug benefits must be obtained through our network pharmacies. The pharmacist will apply any plan deductibles or copays to the prescription cost. These plans have a three-tier plan design. Your out of pocket cost may vary depending on whether you receive a prescription drug in Tier 1, Tier 2 or Tier 3.

Understanding Out of Pocket Costs

Out of pocket costs are costs payable by you for medical and hospital services and prescription drugs. The specific amount of your out of pocket costs may differ depending on the features of your specific plan. These costs include:

- **Deductible** — The portion of eligible costs you must pay during a calendar year before EmblemHealth begins paying for any covered services, except preventive care.
- **Out-of-Pocket Maximum** — The maximum dollar amount per calendar year you will have to pay for covered services.
- **Coinsurance** — A percentage of the eligible cost which you are required to pay after the deductible is met. Coinsurance is paid directly to the provider.
- **Copay** — The set amount which you are required to pay for certain covered services after the deductible is met. A copay is paid directly to the provider.

Select Care Platinum D

SUMMARY OF BENEFITS	
Major Cost-Sharing Provisions	**Comments**
Primary care physician (PCP) office visits	$15 copay per visit
Specialist office visits	$35 copay per visit
Telehealth	$10 physician consulting fee $5 registered dietician fee
Hospital admission	$500 copay per hospital admission
Emergency room copay (waived if admitted)	$100 copay per visit
Annual deductible (individual/family)	$0/$0
Out-of-pocket maximum (individual/family)	$2,000/$4,000
Prescription drugs (retail)	$10 copay generic, $30 copay preferred brand, $60 copay non-preferred brand, $10/$30/$60 copay specialty drugs
Inpatient Hospital Services	
Inpatient physician and surgical services	$100 surgeon copay, $0 cost sharing on all other inpatient professional services
Semi-private room and board	Included in hospital admission copay
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, X-rays and lab tests	Included in hospital admission copay
Speech, physical and occupational therapies (when part of a rehabilitation admission)	Included in hospital admission copay Inpatient rehabilitation therapy is covered for up to one consecutive 60-day period, per condition, per lifetime
Cardiac and pulmonary rehabilitation	Included in hospital copay
Pre-admission testing	Covered in full
Outpatient Medical Care	
PCP office visits	Subject to PCP office visit copay
Specialist office visits	Subject to specialist office visit copay
Preventative care, including physical exams, ear exams, health education and counseling, pap smear, mammography and immunizations	Covered in full
Well-child care	Covered in full
Diagnostic services including X-ray, lab tests, EKGs (outpatient facility)	Subject to specialist office visit copay
Prenatal care in physician's office	Covered in full
Ambulatory surgery	$100 facility copay/$100 surgeon copay
Second medical and surgical opinion	Subject to specialist office visit copay
Chiropractic services	Subject to specialist office visit copay
Radiation therapy and chemotherapy	Subject to PCP office visit copay
Mental Health and Substance Use Disorder	
Mental Health Care • Inpatient treatment of mental illness • Outpatient treatment of mental illness	 Subject to hospital admission copay; no limit on days per calendar year Subject to PCP office visit copay; unlimited visits per calendar year
Substance Use Disorder • Inpatient detoxification and inpatient rehabilitation treatment • Outpatient treatment	 Subject to hospital admission copay; no limit on days per calendar year Subject to PCP office visit copay, unlimited visits per calendar year, includes 20 outpatient visits for family counseling

SUMMARY OF BENEFITS	
Special Kinds of Care	
Emergency and urgent care • In hospital emergency room • In urgent care facility • Ambulance service to the hospital	 $100 copay per visit (waived if admitted) $55 copay $100 copay
Home health care	Subject to PCP office visit copay; 40 visits per calendar year; home infusion, if administered in home by Home Care, then counts toward home care visit limits
Hospice care (outpatient)	Subject to PCP office visit copay; 210 days/lifetime
Skilled nursing facility care	Subject to hospital admission copay; 200 days per calendar year
Dialysis treatment	Subject to PCP office visit copay
Diabetes equipment and supplies (30 day supply)	Subject to PCP office visit copay
Diabetes education	Subject to PCP office visit copay
Outpatient physical, speech and occupational rehabilitative services	$25 copay per visit, 60 visits per condition, per lifetime combined therapies
Outpatient physical, speech and occupational habilitative services	$25 copay per visit, 60 visits per condition, per lifetime combined therapies
Outpatient cardiac and pulmonary therapy	$15 copay per visit
Family planning	No charge
Durable medical equipment	10% coinsurance
Hearing aids	10% coinsurance
Pediatric vision (coverage to age 19) • Refractive eye exams • Eyeglasses/contact lenses	 Subject to PCP office visit copay 10% coinsurance

Certain services must be approved in advance by EmblemHealth.

EmblemHealth Select Care Plans are underwritten by HIP Health Plan of New York. Except for emergency care, the above benefits and services are covered only when provided or referred by a Select Care network primary care physician and/or approved in advance by the EmblemHealth Care Management Program. Participating physicians and providers have contracted with EmblemHealth to provide care to our members; they are not employees, agents, servants or representatives of EmblemHealth. 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. Refer to HIP policy form number 155-23-IOFFHIXCONT (04/15), et al.

Select Care Gold D

SUMMARY OF BENEFITS	
Major Cost-Sharing Provisions	**Comments**
Primary care physician (PCP) office visits	$25 copay per visit after deductible
Specialist office visits	$40 copay per visit after deductible
Telehealth	$10 physician consulting fee $5 registered dietician fee
Hospital admission	$1,000 copay per hospital admission after deductible
Emergency room copay (waived if admitted)	$150 copay per visit after deductible
Annual deductible hospital/medical (individual/family)	$600/$1,200
Out-of-pocket maximum (individual/family)	$4,000/$8,000
Prescription drugs (retail)	$10 copay generic, $35 copay preferred brand, $70 copay non-preferred brand, $10/$35/$70 copay specialty drugs
Inpatient Hospital Services	
Inpatient physician and surgical services	$100 surgeon copay after deductible; $0 cost share for all other inpatient professional services
Semi-private room and board	Included in hospital admission copay after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, X-rays and lab tests	Included in hospital admission copay after deductible
Speech, physical and occupational therapy (when part of a rehabilitation admission)	Included in hospital admission copay after deductible. Inpatient rehabilitation therapy is covered for up to one consecutive 60-day period, per condition, per lifetime for physical, speech and occupational therapies.
Cardiac and pulmonary rehabilitation	Included in hospital copay after deductible
Pre-admission testing	Covered in full
Outpatient Medical Care	
PCP office visits	Subject to PCP office visit copay after deductible
Specialist office visits	Subject to specialist office visit copay after deductible
Preventative care, including physical exams, ear exams, health education and counseling, pap smear, mammography and immunizations	Covered in full
Well-child care	Covered in full
Diagnostic services including X-ray, lab tests, EKGs (outpatient facility)	Subject to specialist office visit copay after deductible
Prenatal care in physician's office	Covered in full
Ambulatory surgery	$100 facility copay after deductible; $100 surgeon copay after deductible
Second medical and surgical opinion	Subject to specialist office visit copay after deductible
Chiropractic services	Subject to specialist office visit copay after deductible
Radiation therapy and chemotherapy	Subject to PCP office visit copay after deductible
Mental Health and Substance Use Disorder	
Mental Health Care • Inpatient treatment of mental illness • Outpatient treatment of mental illness	 Subject to hospital admission copay after deductible; no limit on days per calendar year Subject to PCP office visit copay after deductible; unlimited visits per calendar year
Substance Use Disorder • Inpatient detoxification and inpatient rehabilitation treatment • Outpatient treatment	 Subject to hospital admission copay after deductible; no limit on days per calendar year Subject to PCP office visit copay after deductible, unlimited visits per calendar year, includes 20 outpatient visits for family counseling

SUMMARY OF BENEFITS	
Special Kinds of Care	
Emergency and urgent care • In hospital emergency room • In urgent care facility • Ambulance service to the hospital	 $150 copay per visit after deductible (waived if admitted) $60 copay after deductible $150 copay after deductible
Home health care	Subject to PCP office visit copay after deductible; 40 visits per calendar year; home infusion, if administered in home by Home Care, then counts toward home care visit limits
Hospice care (outpatient)	Subject to PCP office visit copay after deductible; 210 days/lifetime
Skilled nursing facility care	Subject to hospital admission copay after deductible; 200 days per calendar year
Dialysis treatment	Subject to PCP office visit copay after deductible
Diabetes equipment and supplies (30 day supply)	Subject to PCP office visit copay after deductible
Diabetes education	Subject to PCP office visit copay after deductible
Outpatient physical, speech and occupational rehabilitative services	$30 copay per visit after deductible, 60 visits per condition, per lifetime combined therapies
Outpatient physical, speech and occupational habilitative services	$30 copay per visit after deductible, 60 visits per condition, per lifetime combined therapies
Outpatient cardiac and pulmonary therapy	$25 copay per visit
Family planning	No charge
Durable medical equipment	20% coinsurance after deductible
Hearing aids	20% coinsurance after deductible
Pediatric vision (coverage to age 19) • Refractive eye exams • Eyeglasses/contact lenses	 Subject to PCP office visit copay after deductible 20% coinsurance after deductible

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Select Care Silver D

SUMMARY OF BENEFITS	
Major Cost-Sharing Provisions	**Comments**
Primary care physician (PCP) office visits	$30 copay per visit after deductible
Specialist office visits	$50 copay per visit after deductible
Telehealth	$10 physician consulting fee $5 registered dietician fee
Hospital admission	$1,500 copay per hospital admission after deductible
Emergency room copay (waived if admitted)	$150 copay per visit after deductible
Annual deductible hospital/medical (individual/family)	$2,000 / $4,000
Out-of-pocket maximum (individual/family)	$5,500 / $11,000
Prescription drugs (retail)	$10 copay generic, $35 copay preferred brand, $70 copay non-preferred brand, $10/$35/$70 copay specialty drugs
Inpatient Hospital Services	
Inpatient physician and surgical services	$100 surgeon copay after deductible, $0 cost share for all other inpatient professional services
Semi-private room and board	Included in hospital admission copay after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, X-rays and lab tests	Included in hospital admission copay after deductible
Speech, physical, occupational and respiratory therapy (when part of a rehabilitation admission)	Included in hospital admission copay after deductible. Inpatient rehabilitation therapy covered up to one consecutive 60 day period per lifetime
Cardiac and pulmonary rehabilitation	Included in hospital copay after deductible
Pre-admission testing	Covered in full
Outpatient Medical Care	
PCP office visits	Subject to PCP office visit copay after deductible
Specialist office visits	Subject to specialist office visit copay after deductible
Preventative care, including physical exams, ear exams, health education and counseling, pap smear, mammography and immunizations	Covered in full
Well-child care	Covered in full
Diagnostic services including X-ray, lab tests, EKGs (outpatient facility)	Subject to specialist office visit copay after deductible
Prenatal care in physician's office	Covered in full
Ambulatory surgery	$100 facility copay after deductible; $100 surgeon copay after deductible
Second medical and surgical opinion	Subject to specialist office visit copay after deductible
Chiropractic services	Subject to specialist office visit copay after deductible
Radiation therapy and chemotherapy	Subject to PCP office visit copay after deductible
Mental Health and Substance Use Disorder	
Mental Health Care • Inpatient treatment of mental illness • Outpatient treatment of mental illness	Subject to hospital admission copay after deductible; no limit on days per calendar year Subject to PCP office visit copay after deductible; unlimited visits per calendar year
Substance Use Disorder • Inpatient detoxification and inpatient rehabilitation treatment • Outpatient treatment	Subject to hospital admission copay after deductible; no limit on days per calendar year Subject to PCP office visit copay after deductible, unlimited visits per calendar year, includes 20 outpatient visits for family counseling

SUMMARY OF BENEFITS	
Special Kinds of Care	
Emergency and urgent care	
• In hospital emergency room	$150 copay per visit after deductible (waived if admitted)
• In urgent care facility	$70 copay after deductible
• Ambulance service to the hospital	$150 copay after deductible
Home health care	Subject to PCP office visit copay after deductible; 40 visits per calendar year; home infusion, if administered in home by Home Care, then counts toward home care visit limits
Hospice care (outpatient)	Subject to PCP office visit copay after deductible; 210 days/lifetime
Skilled nursing facility care	Subject to hospital admission copay after deductible; 200 days per calendar year
Dialysis treatment	Subject to PCP office visit copay after deductible
Diabetes equipment and supplies (30 day supply)	Subject to PCP office visit copay after deductible
Diabetes education	Subject to PCP office visit copay after deductible
Outpatient physical, speech and occupational rehabilitative services	$30 copay per visit, 60 visits per condition, per lifetime combined therapies.
Outpatient physical, speech and occupational habilitative services	$30 copay per visit, 60 visits per condition, per lifetime combined therapies.
Outpatient cardiac and pulmonary therapy	Subject to PCP office visit copay after deductible
Family planning	No charge
Durable medical equipment	30% coinsurance after deductible
Hearing aids	30% coinsurance after deductible
Pediatric vision (coverage to age 19)	
• Refractive eye exams	Subject to PCP office visit copay after deductible
• Eyeglasses/contact lenses	30% coinsurance after deductible

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Select Care Bronze D

SUMMARY OF BENEFITS	
Major Cost-Sharing Provisions	**Comments**
Primary care physician (PCP) office visits	50% coinsurance after deductible
Specialist office visits	50% coinsurance after deductible
Telehealth	$10 physician consulting fee $5 registered dietician fee
Hospital admission	50% coinsurance after deductible
Emergency room copay (waived if admitted)	50% coinsurance after deductible
Annual deductible hospital/medical and prescriptions (individual/family)	$3,500/$7,000
Out-of-pocket maximum (individual/family)	$6,850/$13,700
Prescription drugs (retail)	$10 copay generic, $35 copay preferred brand, $70 copay non-preferred brand, $10/$35/$70 copay specialty drugs after deductible
Inpatient Hospital Services	
Inpatient physician and surgical services	50% coinsurance after deductible
Semi-private room and board	50% coinsurance after deductible
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, X-rays and lab tests	50% coinsurance after deductible
Speech, physical, occupational and respiratory therapy (when part of a rehabilitation admission)	50% coinsurance after deductible. Inpatient rehabilitation therapy is covered for up to one consecutive 60-day period, per condition, per lifetime
Cardiac and pulmonary rehabilitation	50% coinsurance after deductible
Pre-admission testing	50% coinsurance after deductible
Outpatient Medical Care	
PCP office visits	50% coinsurance after deductible
Specialist office visits	50% coinsurance after deductible
Preventative care, including physical exams, ear exams, health education and counseling, pap smear, mammography and immunizations	Covered in full
Well-child care	Covered in full
Diagnostic services including X-ray, lab tests, EKGs (outpatient facility)	50% coinsurance after deductible
Prenatal care in physician's office	Covered in full
Ambulatory surgery	50% coinsurance after deductible
Second medical and surgical opinion	50% coinsurance after deductible
Chiropractic services	50% coinsurance after deductible
Radiation therapy and chemotherapy	50% coinsurance after deductible
Mental Health and Substance Use Disorder	
Mental Health Care • Inpatient treatment of mental illness • Outpatient treatment of mental illness	 50% coinsurance after deductible; no limit on days per calendar year 50% coinsurance after deductible; unlimited visits per calendar year
Substance Use Disorder • Inpatient detoxification and inpatient rehabilitation treatment • Outpatient treatment	 50% coinsurance after deductible; no limit on days per calendar year 50% coinsurance after deductible; unlimited visits per calendar year; includes 20 outpatient visits per family counseling

SUMMARY OF BENEFITS	
Special Kinds of Care	
Emergency and urgent care	
• In hospital emergency room	50% coinsurance after deductible (waived if admitted)
• In urgent care facility	50% coinsurance after deductible
• Ambulance service to the hospital	50% coinsurance after deductible
Home health care	50% coinsurance after deductible; 40 visits per calendar year; home infusion counts toward home health care visit limits
Hospice care (outpatient)	50% coinsurance after deductible; 210 days/lifetime
Skilled nursing facility care	50% coinsurance after deductible; 200 days per calendar year
Dialysis treatment	50% coinsurance after deductible
Diabetes equipment, supplies and education	50% coinsurance after deductible
Outpatient physical, speech and occupational rehabilitative services	50% coinsurance after deductible; 60 visits per condition, per lifetime combined therapies
Outpatient physical, speech and occupational habilitative services	50% coinsurance after deductible; 60 visits per condition, per lifetime combined therapies
Outpatient cardiac and pulmonary therapy	50% coinsurance after deductible
Family planning	No charge
Durable medical equipment	50% coinsurance after deductible
Hearing aids	50% coinsurance after deductible
Pediatric vision (coverage to age 19)	
• Refractive eye exams	50% coinsurance after deductible
• Eyeglasses/contact lenses	50% coinsurance after deductible

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FirstSmiles Dental

SUMMARY OF BENEFITS	
Major Cost-Sharing Provisions	**Comments**
Annual deductible (Individual)	$0 copay at participating provider Non-participating provider services are not covered
Out-of-pocket maximum (Individual)	$350 Per Child copay at participating provider Non-participating provider services are not covered
Pediatric Dental Care	
Emergency Dental Care	$36 copay at participating provider Non-participating provider services are not covered
Preventive Dental Care	$0 copay at participating provider Non-participating provider services are not covered
Routine Dental Care	$36 copay at participating provider Non-participating provider services are not covered
Endodontics (preauthorization required)	$36 copay at participating provider Non-participating provider services are not covered
Periodontics (preauthorization required)	$36 copay at participating provider Non-participating provider services are not covered
Orthodontics (preauthorization required)	$36 copay at participating provider Non-participating provider services are not covered

Some services are subject to prior authorization. The provider will contact EmblemHealth for prior authorization to perform the service as a covered benefit. This summary is provided for information only; it does not contain complete details of the plan, (which are available only in the Contract and Schedule of Benefits, and it does not constitute an Agreement.

The EmblemHealth FirstSmiles Plan is underwritten by HIP Insurance Plan of New York and provides in-network benefits only. No out-of-network services are covered. Coverage is subject to all terms, conditions, limitations, and exclusions set forth in the contract. Refer to HIP policy form numbers 155-23-OFFIDHIX (04-14).

HMO Direct Pay Plan Rates

Listed below are the monthly premium rates. Excludes premium rate for Pediatric Dental coverage.

Rates are effective 1/1/2016 through 12/31/2016

		Select Care Platinum D	Select Care Gold D	Select Care Silver D	Select Care Bronze D
Downstate (NYC)	Individual	$649.25	$549.38	$452.77	$387.87
	Individual & Spouse	$1,298.50	$1,098.76	$905.54	$775.74
	Parent & Child(ren)	$1,103.73	$933.95	$769.71	$659.38
	Family	$1,850.36	$1,565.73	$1,290.39	$1,105.43
	Child Only	$267.49	$226.34	$186.54	$159.80
Long Island	Individual	$737.84	$624.35	$514.55	$440.80
	Individual & Spouse	$1,475.68	$1,248.70	$1,029.10	$881.60
	Parent & Child(ren)	$1,254.33	$1,061.40	$874.74	$749.36
	Family	$2,102.84	$1,779.40	$1,466.47	$1,256.28
	Child Only	$303.99	$257.23	$211.99	$181.61
Albany	Individual	$777.99	$658.33	$542.55	$464.79
	Individual & Spouse	$1,555.98	$1,316.66	$1,085.10	$929.58
	Parent & Child(ren)	$1,322.58	$1,119.16	$922.34	$790.14
	Family	$2,217.27	$1,876.24	$1,546.27	$1,324.65
	Child Only	$320.53	$271.23	$223.53	$191.49
Mid-Hudson	Individual	$778.33	$658.61	$542.79	$464.99
	Individual & Spouse	$1,556.66	$1,317.22	$1,085.58	$929.98
	Parent & Child(ren)	$1,323.16	$1,119.64	$922.74	$790.48
	Family	$2,218.24	$1,877.04	$1,546.95	$1,325.22
	Child Only	$320.67	$271.35	$223.63	$191.58
Syracuse	Individual	$777.99	$658.33	$542.55	$464.79
	Individual & Spouse	$1,555.98	$1,316.66	$1,085.10	$929.58
	Parent & Child(ren)	$1,322.58	$1,119.16	$922.34	$790.14
	Family	$2,217.27	$1,876.24	$1,546.27	$1,324.65
	Child Only	$320.53	$271.23	$223.53	$191.49
Utica/Watertown	Individual	$777.99	$658.33	$542.55	$464.79
	Individual & Spouse	$1,555.98	$1,316.66	$1,085.10	$929.58
	Parent & Child(ren)	$1,322.58	$1,119.16	$922.34	$790.14
	Family	$2,217.27	$1,876.24	$1,546.27	$1,324.65
	Child Only	$320.53	$271.23	$223.53	$191.49

Albany: Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schoharie, Schenectady, Warren, Washington
Mid-Hudson: Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster
Downstate (NYC): Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester
Syracuse: Broome
Utica/Watertown: Otsego
Long Island: Nassau, Suffolk

All rates and benefits are underwritten by HIP.
Refer to HIP policy form number 155-23-IOFFHIXCONT (04/15), 155-23-IOFFHIXCHILDCONT (04/15), or HIP policy form number 155-23-IHIXD29 (04/15).

HMO Direct Pay Plan Age 29 Rider

Listed below are the monthly premium rates with **age 29 rider** extends coverage for young adults through age 29 (up to 30th birthday). Excludes premium rate for Pediatric Dental coverage.

Rates are effective 1/1/2016 through 12/31/2016

		Select Care Platinum D Age 29	Select Care Gold D Age 29	Select Care Silver D Age 29	Select Care Bronze D Age 29
Downstate (NYC)	Individual	$668.73	$565.86	$466.35	$399.51
	Individual & Spouse	$1,337.46	$1,131.72	$932.70	$799.02
	Parent & Child(ren)	$1,136.84	$961.96	$792.80	$679.17
	Family	$1,905.88	$1,612.70	$1,329.10	$1,138.60
Long Island	Individual	$759.98	$643.08	$529.99	$454.02
	Individual & Spouse	$1,519.96	$1,286.16	$1,059.98	$908.04
	Parent & Child(ren)	$1,291.97	$1,093.24	$900.98	$771.83
	Family	$2,165.94	$1,832.78	$1,510.47	$1,293.96
Albany	Individual	$801.33	$678.08	$558.83	$478.73
	Individual & Spouse	$1,602.66	$1,356.16	$1,117.66	$957.46
	Parent & Child(ren)	$1,362.26	$1,152.74	$950.01	$813.84
	Family	$2,283.79	$1,932.53	$1,592.67	$1,364.38
Mid-Hudson	Individual	$801.68	$678.37	$559.07	$478.94
	Individual & Spouse	$1,603.36	$1,356.74	$1,118.14	$957.88
	Parent & Child(ren)	$1,362.86	$1,153.23	$950.42	$814.20
	Family	$2,284.79	$1,933.35	$1,593.35	$1,364.98
Syracuse	Individual	$801.33	$678.08	$558.83	$478.73
	Individual & Spouse	$1,602.66	$1,356.16	$1,117.66	$957.46
	Parent & Child(ren)	$1,362.26	$1,152.74	$950.01	$813.84
	Family	$2,283.79	$1,932.53	$1,592.67	$1,364.38
Utica/Watertown	Individual	$801.33	$678.08	$558.83	$478.73
	Individual & Spouse	$1,602.66	$1,356.16	$1,117.66	$957.46
	Parent & Child(ren)	$1,362.26	$1,152.74	$950.01	$813.84
	Family	$2,283.79	$1,932.53	$1,592.67	$1,364.38

Albany: Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schoharie, Schenectady, Warren, Washington
Mid-Hudson: Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster
Downstate (NYC): Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester
Syracuse: Broome
Utica/Watertown: Otsego
Long Island: Nassau, Suffolk

All rates and benefits are underwritten by HIP.
Refer to HIP policy form number 155-23-IOFFHIXCONT (04/15), 155-23-IOFFHIXCHILDCONT (04/15) or HIP policy form number 155-23-IHIXD29 (04/15).

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WHAT CARE FEELS LIKE.

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