



# SUMMARY OF BENEFITS

➤ MAJOR COPAYMENT PROVISIONS	HIP PRIME™
PCP Office visits	\$10 copay per visit
Specialist Office visits	\$10 copay per visit
Hospital admission	\$100 copay per Hospital Admission
Emergency room copay (waived if admitted)	\$25 copay per visit
Prescription drugs	\$10 generic / \$10 brand (Subject to Drug Formulary) Contraceptives Included (Formulary copays are reduced by 50% when utilizing the HIP Mail Order Pharmacy Service. Up to a 90 day supply may be obtained.)

➤ INPATIENT HOSPITAL SERVICES	HIP PRIME™
• Hospital and Physician Services	Subject to Hospital admission copay
• 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
• Short-term speech, physical, occupational and respiratory therapy (when part of an acute admission)	Included in Hospital Admission copay Short-term only
• Speech, physical, occupational and respiratory therapy (when part of a rehabilitation admission)	Subject to Hospital admission copay 90 days per calendar year
• Radiation therapy and chemotherapy	Included in Hospital Admission copay
• Pre-admission testing	Included in Hospital Admission copay
• Human organ transplants	Included in Hospital Admission copay

➤ OUTPATIENT MEDICAL CARE	HIP PRIME™
• PCP office visits	Subject to PCP office visit copay
• Specialist office visits	Subject to Specialist office visit copay
• Preventive care, including physical exams, ear exams, health education and counseling, pap smear, mammography and immunizations	\$0 Copay
• Well-child care	No copay
• Diagnostic services including X-ray, lab tests, EKG's	Included in PCP office visit copay
• Prenatal, postnatal care in physician's office	No copay
• Ambulatory surgery	\$50 copay per visit
• Second medical and surgical opinion	No copay
• Routine foot care	Not covered
• Chiropractic services	Subject to Specialist office visit copay



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➤ MENTAL HEALTH AND SUBSTANCE USE DISORDER	HIP PRIME™
<b>Mental Health Care</b>	
• <b>Inpatient</b>	
- Treatment of Mental Illness	Subject to Hospital admission copay; Unlimited days per calendar year
• <b>Outpatient</b>	
- Treatment of Mental Illness	\$10 copay Unlimited Visits per calendar year
<b>Substance Use Disorder</b>	
• Inpatient Detoxification	Subject to Hospital admission copay No limit on days per calendar year
• Inpatient Rehabilitation Treatment	Subject to Hospital admission copay Unlimited days per calendar year
• Outpatient Rehabilitation Treatment	\$10 Copay per visit, Unlimited Visit - per calendar year

➤ SPECIAL KINDS OF CARE	HIP PRIME™
<b>Emergency and urgent Care</b>	
• In hospital emergency room	Subject to Emergency room copay
• In urgent care facility	Subject to PCP office visit copay
• In physician's office	Subject to PCP office visit copay
• Ambulance service to the hospital	No copay
<b>Home Health Care</b>	No copay; 200 visits per calendar year
<b>Hospice Care</b>	No copay; 210 days
<b>Skilled Nursing Facility care</b>	\$0 copay; Unlimited days per calendar year
<b>Dialysis treatment</b>	\$10 copay per visit
<b>Diabetes equipment, supplies and education</b>	\$10 copay per month
<b>Outpatient physical, speech, occupational and respiratory therapy.</b>	Subject to Specialist office visit copay; 90 visits per calendar year
<b>Family Planning Services</b>	Covered
<b>Infertility Diagnosis and Treatment</b>	Subject to applicable copays
<b>In-vitro Fertilization</b>	Not Covered
<b>Dental Care</b>	
• General dental care	Covered at reduced member fee schedule



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<ul style="list-style-type: none"> <li>Preventive dental care <ul style="list-style-type: none"> <li>- Oral exam (One every six months)</li> <li>- Cleaning (One every six months)</li> <li>- Topical application of fluoride for children age 16 and under (One every six months)</li> <li>- Fluoride applications age 17 and over (One every six months)</li> </ul> </li> </ul>	<p>\$5 copay per visit  \$10 copay per visit  \$5 copay per visit</p> <p>Copay to be determined by zip code</p>
<b>Durable Medical Equipment</b>	\$0 annual deductible
<b>Private Duty Nursing</b>	Covered in full
<b>Hearing aids</b>	Not covered; Cochlear implants covered
<b>Optical care</b>	\$10 copay
<ul style="list-style-type: none"> <li>Refractive Eye Exams</li> <li>Eyeglasses</li> </ul>	Every 24 months:\$80 frame allowance;\$35 co-pay for lenses

➤ ADDITIONAL BENEFITS	HIP PRIME™
<ul style="list-style-type: none"> <li>Nurse Advice Line</li> </ul>	Not Covered
<ul style="list-style-type: none"> <li>Wellness Rider</li> </ul>	Not Covered
<ul style="list-style-type: none"> <li>Maximum Out of Pocket(MOOP)</li> </ul>	Individual \$6,600/Family \$13,200
<ul style="list-style-type: none"> <li>Telemedicine</li> </ul>	Not Covered

**FOOTNOTES**

\* Drugs are dispensed in accordance with HIP's Drug Formulary. Please refer to your Prescription Drug Rider for details.

*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 the HIP Care Management Program. 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 Schedule of Benefits, and it does not constitute an Agreement. HIP Health Plan of New York (HIP) is an EmblemHealth company.*