



# SUMMARY OF BENEFITS

MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE CARE	HIP PRIME™
<b>Mental Health Care</b>	
• Inpatient	No copay; 30 days per calendar year
• Outpatient	\$0 copay; 60 visits per calendar year
<b>Alcohol and Substance Abuse Care</b>	
• Inpatient Detoxification	No copay; 7 days per calendar year
• Inpatient Rehabilitation Treatment	No copay; 30 days per calendar year
• Outpatient Rehabilitation Treatment	No copay; 60 visits per calendar year

SPECIAL KINDS OF CARE	HIP PRIME™
<b>Emergency and urgent care</b>	
• In hospital emergency room	No copay
• In urgent care facility	No copay
• In physicians office	No copay
• Ambulance service to 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>	No copay; Unlimited days
<b>Dialysis treatment</b>	\$10 copay per visit
<b>Diabetes equipment, supplies and education</b>	No copay
<b>Outpatient physical, speech, occupational and respiratory therapy.</b>	No copay; 90 visits per calendar year
<b>Family Planning Services</b>	Covered
<b>Dental Care</b>	
• General Dental Care	Covered at reduced member fee schedule
• Preventive Dental	Oral exam (One every six months - \$5 copay per visit) Cleaning, including one application of fluoride for children age 16 and under (One every six months - \$10 copay per visit)
<b>Durable Medical Equipment</b>	\$50 annual deductible
<b>Private Duty Nursing</b>	After the first 72 hours, covered 80% up to 504 hours
<b>Hearing Aids</b>	Not Covered, Cochlear implants covered
<b>Optical Care</b>	
• Refractive Eye Exams	No copay
• Eyeglasses	\$45 for a complete pair every 24 months

**IMPORTANT:**

<sup>1</sup> 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 Member Advocacy 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 Certificate of Coverage and Schedule of Benefits, and it does not constitute an Agreement.



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MAJOR COPAYMENT PROVISIONS	HIP PRIME™
PCP Office visits	No copay
Specialist Office visits	No copay
Hospital admission	No copay
Emergency Room copay	\$25 copay
Prescription drugs	\$10 generic/ \$20 brand (Subject to Drug Formulary <sup>1</sup> ) (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	No copay
• Semi-private room and board	No copay
• Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, X-rays and lab tests	No copay
• Short-term speech, physical, occupational and respiratory therapy (when part of an acute admission)	No copay Short-term only
• Speech, physical, occupational and respiratory therapy (when part of a rehabilitation admission)	No copay; 90 days per calendar year
• Radiation therapy and chemotherapy	No copay
• Pre-admission testing	No copay
• Human organ transplants	No copay

OUTPATIENT MEDICAL CARE	HIP PRIME™
• PCP office visits	No copay
• Specialists office visits	No copay
• Preventive care, including physical exams, eye and eye exams, health education and counseling, pap smear, mammography and immunizations	No copay
• Well-child care to age 19 including immunizations	No copay
• Diagnostic services including X-ray, lab tests, EKG's, MRI's and CAT scans	No copay
• Prenatal, postnatal care in physician's office	No copay
• Ambulatory surgery	No copay
• Second medical and surgical opinion	No copay
• Wheelchairs	Covered under DME rider
• Routine foot care	Not covered
• Chiropractic services	No copay

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