



SUMMARY OF BENEFITS

➤ MAJOR COPAYMENT PROVISIONS	HIP PRIME™
PCP Office visits	No copay
Specialist Office visits	No copay
Hospital admission	No copay
Emergency Room copay	No copay
Prescription drugs	\$5 generic/ \$5 brand (Subject to Drug Formulary ¹) (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
• Outpatient hospital services and ambulatory surgery including physician and facility services	No copay
• Second medical and surgical opinion	No copay
• Disposable Medical supplies	No copay
• Wheelchairs	Covered under DME rider
• Routine foot care	Not covered
• Chiropractic services	No copay

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SUMMARY OF BENEFITS

➤ MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE CARE	HIP PRIME™
Mental Health Care	
• Inpatient	No copay; 30 days per calendar year
• Outpatient	No copay; 60 visits per calendar year
Alcohol and Substance Abuse Care	
• Inpatient Detoxification	No copay; 7 days per calendar year
• Inpatient Rehabilitation Treatment	Not Covered
• Outpatient Rehabilitation Treatment	No copay; 60 visits per calendar year

➤ SPECIAL KINDS OF CARE	HIP PRIME™
Emergency and urgent care	
• In hospital emergency room	No copay
• In urgent care facility	No copay
• In physicians office	No copay
• Ambulance service to hospital	No copay
Home health care	No copay; 200 visits per calendar year
Hospice care	No copay; 210 days
Skilled Nursing Facility care	No copay; Unlimited days
Dialysis treatment	\$10 copay per visit
Diabetes equipment, supplies and education	No copay
Outpatient physical, speech, occupational and respiratory therapy.	No copay; 90 visits per calendar year
InterPlan® Care	Covered (Chronic condition only)
Family Planning Services	Covered
Dental Care	
• 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)
Durable Medical Equipment	\$0 annual deductible
Private Duty Nursing	100%
Hearing Aids	Not Covered, Cochlear implants covered
Optical Care	
• Refractive Eye Exams	No copay
• Eyeglasses	\$45 for a complete pair

FOOTNOTES

¹ *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 or Certificate of Coverage and Schedule of Benefits, and it does not constitute an Agreement.