



# SUMMARY OF BENEFITS FOR HIP Select EPO

## EPO 30/50 1000 Select



DEDUCTIBLES	COINSURANCE	COINSURANCE MAXIMUM	ANNUAL MAXIMUM BENEFIT
<b>In-Network:</b> \$1,000 Individual, \$2,000 Family	<b>In-Network:</b> Member pays 10%	<b>In-Network:</b> \$1,000 Individual, \$2,000 Family	<b>In-Network:</b> Unlimited
<b>PROFESSIONAL SERVICES</b>		<b>PARTICIPATING PROVIDER</b>	
<b>PCP Office Visits</b>		\$30 copay per visit	
<b>Specialist Office Visits</b>		\$50 copay per visit	
<b>Diagnostic Services</b> X-rays, lab tests and EKG's		Included in the PCP office visit copay	
<b>Chiropractic Care</b>		Same as Specialist office visit copay	
<b>● INPATIENT HOSPITAL SERVICES*</b>		<b>PARTICIPATING PROVIDER</b>	
<b>Semi-private Room and Board</b>		Subject to Deductible and Coinsurance	
<b>Hospital and Physician Services</b>		Subject to Deductible and Coinsurance	
<b>Operating and Recovery Room</b>			
<b>Intensive and Special Care Units</b>			
<b>General Nursing Care</b>			
<b>Prescribed Drugs</b>			
<b>Anesthesia</b>			
<b>X-rays and Lab Tests</b>			
<b>Short-term Speech, Physical, Cardiac, Occupational and Respiratory Therapy</b> (when part of an acute admission)		(Short-term only) Subject to Deductible and Coinsurance	
<b>Speech, Physical, Occupational and Respiratory Therapy</b> (when part of a rehabilitation admission)		30 days per calendar year Subject to Deductible and Coinsurance	
<b>Radiation Therapy and Chemotherapy</b>		Subject to Deductible and Coinsurance	
<b>Pre-admission Testing</b>		Subject to Deductible and Coinsurance	
<b>Human Organ Transplants</b>		Subject to Deductible and Coinsurance	
<b>OUTPATIENT FACILITY SERVICES</b>		<b>PARTICIPATING PROVIDER</b>	
<b>Emergency Room Copay</b>		\$50 copay per visit (waived if admitted)	
<b>Ambulatory Surgery*</b>		Subject to Deductible and Coinsurance	
<b>Diagnostic &amp; Therapeutic Services including MRI's, MRA's, PET and CAT scans-</b>		Subject to Deductible and Coinsurance	
<b>Outpatient Hospital Facility Services</b>			
<b>Renal Dialysis</b>		\$20 copay	
<b>OUTPATIENT MEDICAL CARE</b>		<b>PARTICIPATING PROVIDER</b>	
<b>Preventive Care</b> Physical exams Ear exams Health education and counseling Pap smear Mammography Prostate cancer screening		Included in the PCP or Specialist office visit copay	
<b>Well-Child Care</b> (to age 19 including immunizations)		\$0 copay	
<b>Prenatal and Postnatal Care</b> (in physician's office)		\$0 copay	
<b>Second Medical and Surgical Opinion</b>		Same as Specialist office visit copay	



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PRESCRIPTION DRUGS	PARTICIPATING PHARMACY
<b>Prescription Drugs Received at:</b> HIP participating pharmacies	\$20 generic /\$30 brand copay (Subject to Drug Formulary) Contraceptives Included; \$50 for Non-Formulary Unlimited Brand Maximum (Formulary copays are reduced by 50% when utilizing the HIP Mail Order Pharmacy Service.)
➤ MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE CARE	PARTICIPATING PROVIDER
<b>Mental Health Care</b> Inpatient care **	30 days per calendar year Subject to Deductible and Coinsurance
Outpatient care	\$25 copay per visit; 20 visits per calendar year
<b>Alcohol and Substance Abuse Care</b> Inpatient detoxification **	7 days per calendar year Subject to Deductible and Coinsurance
Inpatient rehabilitation treatment **	30 days per calendar year Subject to Deductible and Coinsurance
Outpatient rehabilitation treatment	60 visits per calendar year; Subject to the Specialist office visit copay
➤ SPECIAL KINDS OF CARE	PARTICIPATING PROVIDER
<b>Emergency and Urgent Care</b> Ambulance service to the hospital In urgent care facility In physician's office	Covered in full Subject to the PCP or Specialist office visit copay Subject to the PCP or Specialist office visit copay
<b>Home Health Care*</b>	40 visits per calendar year
<b>Hospice Care*</b>	210 days, lifetime maximum Subject to Deductible and Coinsurance
<b>Skilled Nursing Facility Care*</b>	30 days per calendar year Subject to Deductible and Coinsurance
<b>Diabetes Equipment, Supplies and Education</b>	\$30 copay per month
<b>Outpatient Physical, Speech, Occupational and Respiratory Therapy</b>	30 visits per calendar year; \$50 copay per visit
<b>Infertility Diagnosis and Treatment</b>	Subject to applicable copays
<b>Family Planning</b>	Covered
<b>Dental Care</b> General dental care	Covered at reduced member fee schedule
Preventive dental care - Oral exam (One every six months) - Cleaning (One every six months) - Topical application of fluoride for children age 16 and under (One every six months) - Fluoride applications age 17 and over (One every six months)	\$5 copay per visit \$10 copay per visit \$5 copay per visit  Copay to be determined by zip code
<b>Durable Medical Equipment*</b>	\$0 annual deductible
<b>Private Duty Nursing</b>	100%
<b>Hearing Aids</b>	Not Covered; Cochlear implants covered
<b>Optical Care</b> Refractive eye exams	\$0 copay
Eyeglasses	\$0 copay; one pair every 12 months
Contacts	\$25 copay; one pair every 12 months



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➤ ADDITIONAL BENEFITS	PARTICIPATING PROVIDER
Health Fitness Center Reimbursement	Available
Alternative Medicine (Nutrition, Acupuncture and Massage)	Covered

### FOOTNOTES

*HIP Participating 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.*

*\*Services must be approved in advance by the HIP Care Management Program.*

*\*\*Services must be approved in advance by the HIP Mental Health department.*

*In-Network benefits are paid based on the lesser amount listed on the Schedule of Services or the actual amount charged by the dentist. Procedures not listed on the Schedule of Services will **not** be paid.*