



SUMMARY OF BENEFITS FOR HIP Select EPO EPO 30/50 1000A Select

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



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PRESCRIPTION DRUGS	PARTICIPATING PHARMACY
Prescription Drugs Received at: HIP participating pharmacies	\$15 generic copay (Subject to Drug Formulary) Contraceptives Included; \$0 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
Mental Health Care Inpatient care **	30 days per calendar year Subject to Deductible and Coinsurance
Outpatient care	\$25 copay per visit; 20 visits per calendar year
Alcohol and Substance Abuse Care 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
Emergency and Urgent Care 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
Home Health Care*	40 visits per calendar year
Hospice Care*	210 days, lifetime maximum Subject to Deductible and Coinsurance
Skilled Nursing Facility Care*	30 days per calendar year Subject to Deductible and Coinsurance
Diabetes Equipment, Supplies and Education	\$30 copay per month
Outpatient Physical, Speech, Occupational and Respiratory Therapy	30 visits per calendar year; \$50 copay per visit
Infertility Diagnosis and Treatment	Subject to applicable copays
Family Planning	Covered
Dental Care 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
Durable Medical Equipment*	\$0 annual deductible
Private Duty Nursing	100%
Hearing Aids	Not Covered; Cochlear implants covered
Optical Care 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.*