



SUMMARY OF BENEFITS FOR HIP Select PPO

PPO 15/1000 Select

➤ DEDUCTIBLES	➤ COINSURANCE	➤ COINSURANCE MAXIMUM	➤ ANNUAL MAXIMUM BENEFIT
In-Network: \$1,000 Individual; \$2,000 Family	In-Network: Member pays 10%	In-Network: \$500 Individual; \$1,000 Family	In-Network: Unlimited
Out-of-Network: \$1,000 Individual; \$2,000 Family	Out-of-Network: Member pays 20%	Out-of-Network: \$3,000 Individual; \$6,000 Family	Out-of-Network: Unlimited
➤ PROFESSIONAL SERVICES (PARTICIPATING PROVIDER)	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	
PCP Office Visits	\$15 copay per visit	Subject to Deductible and Coinsurance	
Specialist Office Visits	\$15 copay per visit	Subject to Deductible and Coinsurance	
Diagnostic Services • X-rays, lab tests and EKG's	Included in the PCP office visit copay	Subject to Deductible and Coinsurance	
Chiropractic Care	Same as Specialist office visit copay	Subject to Deductible and Coinsurance	
➤ INPATIENT HOSPITAL SERVICES*	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	
Semi-private Room and Board	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
Hospital and Physician Services Operating and Recovery Room Intensive and Special Care Units General Nursing Care Prescribed Drugs Anesthesia X-rays and Lab Tests	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
Short-term Speech, Physical, Cardiac, Occupational and Respiratory Therapy (when part of an acute admission)	Subject to Deductible and Coinsurance; (Short-term only)	Subject to Deductible and Coinsurance	
Speech, Physical, Occupational and Respiratory Therapy (when part of a rehabilitation admission)	30 days per calendar year; Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
Radiation Therapy and Chemotherapy	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
Pre-admission Testing	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
Human Organ Transplants	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
➤ OUTPATIENT FACILITY SERVICES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	
Emergency Room Copay	\$50 copay per visit (waived if admitted)	\$50 copay per visit (waived if admitted)	
Ambulatory Surgery*	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
Diagnostic & Therapeutic Services Including MRI's, MRA's, PET and CAT scans • Outpatient Hospital Facility services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
Renal Dialysis	\$20 copay per visit	Subject to Deductible and Coinsurance	



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➤ OUTPATIENT MEDICAL CARE	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Preventive Care <ul style="list-style-type: none"> Physical exams Ear exams Health education and counseling Pap smear Mammography Prostate cancer screening 	Included in the PCP or Specialist office visit copay	Subject to Deductible and Coinsurance
Well-child Care (to age 19 including immunizations)	\$0 copay	Subject to Deductible and Coinsurance
Prenatal and Postnatal Care (in physician's office)	\$0 copay	Subject to Deductible and Coinsurance
Second Medical and Surgical Opinion	Same as Specialist office visit copay	Subject to Deductible and Coinsurance
➤ PRESCRIPTION DRUGS	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Prescription Drugs Received at: <ul style="list-style-type: none"> HIP participating pharmacies 	\$15 generic / \$30 brand copay (Subject to Drug Formulary) Contraceptives included; \$50 Non-Formulary Unlimited Brand Maximum	Not covered
<ul style="list-style-type: none"> HIP Mail Order Pharmacy Service (Up to a 90 day supply may be obtained) 	Formulary copays are reduced by 50% when utilizing the HIP Mail Order Pharmacy Service	Not covered
➤ MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE CARE	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Mental Health Care <ul style="list-style-type: none"> Inpatient care ** 	30 days per calendar year; Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
<ul style="list-style-type: none"> Outpatient care 	\$15 copay per visit; 20 visits per calendar year	Subject to Deductible and Coinsurance
Alcohol and Substance Abuse Care <ul style="list-style-type: none"> Inpatient detoxification ** 	7 days per calendar year; Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
<ul style="list-style-type: none"> Inpatient rehabilitation treatment ** 	30 days per calendar year; Subject to Deductible and coinsurance	Subject to Deductible and Coinsurance
<ul style="list-style-type: none"> Outpatient rehabilitation treatment 	60 visits per calendar year Subject to Specialist office visit copay	Subject to Deductible and Coinsurance
➤ SPECIAL KINDS OF CARE	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Emergency and Urgent Care <ul style="list-style-type: none"> Ambulance service to hospital 	Covered in full	Subject to Deductible and Coinsurance
<ul style="list-style-type: none"> In urgent care facility 	Subject to PCP or Specialist office visit copay	Subject to Deductible and Coinsurance
<ul style="list-style-type: none"> In physician's office 	Subject to PCP or Specialist office visit copay	Subject to Deductible and Coinsurance



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➤ SPECIAL KINDS OF CARE (CONT'D)	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Home Health Care *	40 visits per calendar year; Subject to deductibles and Coinsurance	Subject to Deductible and Coinsurance
Hospice Care *	210 days lifetime maximum; Subject to Deductible and Coinsurance	Not covered
Skilled Nursing Facility Care *	30 days per calendar year; Subject to Deductible and Coinsurance	Not covered
Diabetes Equipment, Supplies and Education	\$15 copay per month	Subject to Deductible and Coinsurance
Outpatient Physical, Speech, Occupational and Respiratory Therapy	30 visits per calendar year; Subject to Specialist office visit copay	Subject to Deductible and Coinsurance
Family Planning	Covered	Covered
Infertility Diagnosis and Treatment	Subject to applicable copay	Subject to Deductible and Coinsurance
Dental Care		
• General dental care	Covered at reduced member fee schedule	Not covered
• 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	Not covered
Durable Medical Equipment *	\$0 annual deductible	Not covered
Private Duty Nursing	100%	Not covered
Hearing Aids	Not covered; Cochlear implants covered	Not covered
Optical Care		
• Refractive eye exams	\$0 copay	Subject to Deductible and Coinsurance
• Eyeglasses	\$0 copay; one pair every 12 months	Not covered
• Contacts	\$25 copay; one pair every 12 months	Not covered
➤ ADDITIONAL BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Health Fitness Center Reimbursement	Available	Not Applicable
Alternative Medicine (Nutrition, Acupuncture and Massage)	Covered	Not Applicable

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.*

*Out-of-Network benefits are paid based on the Schedule of Services in the geographic area where the service is provided. Members are responsible to pay the difference between the allowed amount and the **non-participating** dentist's usual fee. All benefits are payable subject to the applicable deductible and coinsurance. Procedures not listed on the Schedule of Services will **not** be paid.*