

SUMMARY OF BENEFITS FOR HIP Select PPO

2ND QUARTER 2011 ASSOC-PFSLTB018-SG

➤ DEDUCTIBLES	➤ COINSURANCE	➤ COINSURANCE MAXIMUM	➤ ANNUAL MAXIMUM BENEFIT
In-Network: Individual \$2000 / Family \$4000	In-Network: Members pays 20%	In-Network: Individual \$5000/ Family \$10000	In-Network: Unlimited
Out-of-Network Individual \$4000 / Family \$8000	Out-of-Network Members pays 40%	Out-of-Network Individual \$10000 / Family \$20000	Out-of-Network Unlimited
➤ PROFESSIONAL SERVICES (PARTICIPATING PROVIDER)	PARTICIPATING PROVIDER <i>(Total day/visit limits include those received from Participating and/or Non-Participating Providers)</i>	NON-PARTICIPATING PROVIDER <i>(Total day/visit limits include those received from Participating and/or Non-Participating Providers)</i>	
PCP Office Visits	\$30 copay per visit	Subject to Deductible and Coinsurance	
Specialist Office Visits	\$50 copay per visit	Subject to Deductible and Coinsurance	
Diagnostic Services • X-rays, lab tests, 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 <i>(Total day/visit limits include those received from Participating and/or Non-Participating Providers)</i>	NON-PARTICIPATING PROVIDER <i>(Total day/visit limits include those received from Participating and/or Non-Participating Providers)</i>	
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	

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➤ OUTPATIENT FACILITY SERVICES	PARTICIPATING PROVIDER <i>(Total day/visit limits include those received from Participating and/or Non-Participating Providers)</i>	NON-PARTICIPATING PROVIDER <i>(Total day/visit limits include those received from Participating and/or Non-Participating Providers)</i>
Emergency Room Copay (waived if admitted)	\$150 copay per visit	\$150 copay per visit
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
➤ OUTPATIENT MEDICAL CARE	PARTICIPATING PROVIDER <i>(Total day/visit limits include those received from Participating and/or Non-Participating Providers)</i>	NON-PARTICIPATING PROVIDER <i>(Total day/visit limits include those received from Participating and/or Non-Participating Providers)</i>
Preventive Care • Physical exams • Ear exams • Health education and counseling • Pap smear • Mammography • Prostate cancer screening	\$0 Copay	\$0 Copay
Well-child Care	\$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: • HIP participating pharmacies	\$10 generic only; \$100 deductible (Subject to Drug Formulary) Contraceptives Included(Formulary copays are reduced by 50% when utilizing the HIP Mail Order Pharmacy Service. Up to a 90 day supply may be obtained.)	Not Covered

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➤ MENTAL HEALTH AND SUBSTANCE USE DISORDER	PARTICIPATING PROVIDER <i>(Total day/visit limits include those received from Participating and/or Non-Participating Providers)</i>	NON-PARTICIPATING PROVIDER <i>(Total day/visit limits include those received from Participating and/or Non-Participating Providers)</i>
Mental Health Care		
<ul style="list-style-type: none"> Inpatient care** -Treatment of Mental Illness 	Subject to Deductible and Coinsurance 30 days per calendar year	Subject to Deductible and Coinsurance
<ul style="list-style-type: none"> Outpatient care -Treatment of Mental Illness 	\$50 copay; 40 visits per calendar year	Subject to Deductible and Coinsurance
Substance Use Disorder		
<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 	\$25 Copay per visit, 60 Visit Limit - per calendar year	Subject to Deductible and Coinsurance
➤ SPECIAL KINDS OF CARE	PARTICIPATING PROVIDER <i>(Total day/visit limits include those received from Participating and/or Non-Participating Providers)</i>	NON-PARTICIPATING PROVIDER <i>(Total day/visit limits include those received from Participating and/or Non-Participating Providers)</i>
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
Home Health Care *	40 visits per calendar year; Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Hospice Care *	210 days lifetime maximum Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Skilled Nursing Facility Care *	30 days per calendar year; Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Diabetes Equipment, Supplies and Education	\$25 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 Services	Covered	Subject to Deductible and Coinsurance
Infertility Diagnosis and Treatment	Subject to applicable copays	Subject to Deductible and Coinsurance
Dental Care		
<ul style="list-style-type: none"> General dental care 	Covered at reduced member fee schedule	Not covered

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<ul style="list-style-type: none"> Preventive dental care <ul style="list-style-type: none"> - 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 *	Not Covered	Not covered
Private Duty Nursing	Not Covered	Not covered
Hearing Aids	Not covered; Cochlear implants covered	Not covered
Optical Care <ul style="list-style-type: none"> Refractive eye exams Eyeglasses 	\$25 copay \$0 for a complete pair of eyeglasses, and \$25 for contacts every 12 months	Subject to Deductible and Coinsurance Not covered

➤ ADDITIONAL BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Health Fitness Center Reimbursement	Included	Not Covered
Alternative Medicine (Nutrition, Acupuncture and Massage)	\$20 Copay	Not 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.

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.

HIP Insurance Company of New York is an EmblemHealth company.