



# SUMMARY OF BENEFITS FOR HIP Select PPO

➤ DEDUCTIBLES	➤ COINSURANCE	➤ COINSURANCE MAXIMUM	➤ ANNUAL MAXIMUM BENEFIT
<b>In-Network:</b> \$2,000 Individual; \$4,000 Family	<b>In-Network:</b> Member pays 20%	<b>In-Network:</b> \$5,000 Individual; \$10,000 Family	<b>In-Network:</b> Unlimited
<b>Out-of-Network:</b> \$4,000 Individual; \$8,000 Family	<b>Out-of-Network:</b> Member pays 40%	<b>Out-of-Network:</b> \$10,000 Individual; \$20,000 Family	<b>Out-of-Network:</b> Unlimited
➤ PROFESSIONAL SERVICES (PARTICIPATING PROVIDER)	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	
<b>PCP Office Visits</b>	\$30 copay per visit	Subject to Deductible and Coinsurance	
<b>Specialist Office Visits</b>	\$50 copay per visit	Subject to Deductible and Coinsurance	
<b>Diagnostic Services</b> • X-rays, lab tests and EKG's	Included in the PCP office visit copay	Subject to Deductible and Coinsurance	
<b>Chiropractic Care</b>	Same as Specialist office visit copay	Subject to Deductible and Coinsurance	
➤ INPATIENT HOSPITAL SERVICES*	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	
<b>Semi-private Room and Board</b>	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
<b>Hospital and Physician Services Operating and Recovery Room Intensive and Special Care Units General Nursing Care Prescribed Drugs Anesthesia X-rays and Lab Tests</b>	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
<b>Short-term Speech, Physical, Cardiac, Occupational and Respiratory Therapy</b> (when part of an acute admission)	Subject to Deductible and Coinsurance; (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	Subject to Deductible and Coinsurance	
<b>Radiation Therapy and Chemotherapy</b>	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
<b>Pre-admission Testing</b>	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
<b>Human Organ Transplants</b>	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
➤ OUTPATIENT FACILITY SERVICES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	
<b>Emergency Room Copay</b>	\$150 copay per visit (waived if admitted)	\$150 copay per visit (waived if admitted)	
<b>Ambulatory Surgery*</b>	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
<b>Diagnostic &amp; Therapeutic Services Including MRI's, MRA's, PET and CAT scans-</b> • Outpatient Hospital Facility services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	
<b>Renal Dialysis</b>	\$20 copay per visit	Subject to Deductible and Coinsurance	



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➤ OUTPATIENT MEDICAL CARE	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>Physical exams</li> <li>Ear exam</li> <li>Health education and counseling</li> <li>Pap smear</li> <li>Mammography</li> <li>Prostate cancer screening</li> </ul>	Included in the PCP or Specialist office visit copay	Subject to Deductible and Coinsurance
<b>Well-child Care</b> (to age 19 including immunizations)	\$0 copay	Subject to Deductible and Coinsurance
<b>Prenatal and Postnatal Care</b> (in physician's office)	\$0 copay	Subject to Deductible and Coinsurance
<b>Second Medical and Surgical Opinion</b>	Same as Specialist office visit copay	Subject to Deductible and Coinsurance
➤ PRESCRIPTION DRUGS	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
<b>Prescription Drugs Received at:</b> <ul style="list-style-type: none"> <li>HIP participating pharmacies</li> </ul>	\$10 generic copay (Subject to Drug Formulary) \$100 deductible; Contraceptives included; \$0 brand maximum	Not covered
<ul style="list-style-type: none"> <li>HIP Mail Order Pharmacy Service                (Up to a 90 day supply may be obtained)</li> </ul>	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
<b>Mental Health Care</b> <ul style="list-style-type: none"> <li>Inpatient care **</li> </ul>	30 days per calendar year; Subject Deductible and Coinsurance	Subject to Deductible and Coinsurance
<ul style="list-style-type: none"> <li>Outpatient care</li> </ul>	\$50 copay per visit; 40 visits per calendar year	Subject to Deductible and Coinsurance
<b>Alcohol and Substance Abuse Care</b> <ul style="list-style-type: none"> <li>Inpatient detoxification **</li> </ul>	7 days per calendar year; Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
<ul style="list-style-type: none"> <li>Inpatient rehabilitation treatment **</li> </ul>	30 days per calendar year; Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
<ul style="list-style-type: none"> <li>Outpatient rehabilitation treatment</li> </ul>	60 visits per calendar year \$50 copay per visit	Subject to Deductible and Coinsurance
➤ SPECIAL KINDS OF CARE	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
<b>Emergency and Urgent Care</b> <ul style="list-style-type: none"> <li>Ambulance service to hospital</li> </ul>	Covered in full	Subject to Deductible and Coinsurance
<ul style="list-style-type: none"> <li>In urgent care facility</li> </ul>	Subject to PCP or Specialist office visit copay	Subject to Deductible and Coinsurance
<ul style="list-style-type: none"> <li>In physician's office</li> </ul>	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
<b>Home Health Care *</b>	40 visits per calendar year; Subject to Deductibles and Coinsurance	Subject to Deductible and Coinsurance
<b>Hospice Care *</b>	210 days lifetime maximum; Subject to Deductible and Coinsurance	Not covered
<b>Skilled Nursing Facility Care *</b>	30 days per calendar year; Subject to Deductible and Coinsurance	Not covered
<b>Diabetes Equipment, Supplies and Education</b>	\$30 copay per month	Subject to Deductible and Coinsurance
<b>Outpatient Physical, Speech, Occupational and Respiratory Therapy</b>	30 visits per calendar year Subject to Specialist office visit copay	Subject to Deductible and Coinsurance
<b>Family Planning</b>	Covered	Covered
<b>Infertility Diagnosis and Treatment</b>	Subject to applicable copay	Subject to Deductible and Coinsurance
<b>Dental Care</b>		
• 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
<b>Durable Medical Equipment *</b>	Not covered	Not covered
<b>Private Duty Nursing</b>	Not covered	Not covered
<b>Hearing Aids</b>	Not covered; Cochlear implants covered	Not covered
<b>Optical Care</b>		
• Refractive eye exams	\$25 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.*