

<b>Feature</b>	<b>HIP Prime High Copay Option - Pre-65</b>
<b>Provider</b>	HIP Health Plan of NY Enrollment: 1-800-447-8632 Ongoing: 1-800-447-8255 <a href="http://www.hipusa.com">www.hipusa.com</a>
<b>Cost Sharing</b>	
<b>Annual Deductible</b>	\$0 Individual; \$0 Family
<b>Out-of-pocket maximum</b>	\$0 Individual; \$0 Family
<b>Lifetime coverage limit</b>	Limit does not apply
<b>Policies/Requirements</b>	
<b>Need to file claims</b>	No; except for covered urgent or emergency care received outside of the service area
<b>Domestic partner benefits</b>	Yes
<b>Access</b>	
<b>Ability to self-refer to OB/GYN</b>	Yes
<b>Ability to self-refer to specialists</b>	No
<b>Out-of-area dependent coverage</b>	No
<b>Out-of-area participant coverage</b>	No
<b>Spending Account</b>	
<b>HRA -- You only</b>	Not applicable
<b>HRA -- You and spouse</b>	Not applicable
<b>HRA -- You and child</b>	Not applicable
<b>HRA -- You and family</b>	Not applicable
<b>Eligible expenses for reimbursement</b>	Not applicable
<b>Outpatient Services</b>	
<b>Primary doctor office visit</b>	\$10 copay
<b>Specialist doctor office visit</b>	\$15 copay
<b>Preventive Care</b>	
<b>Annual physical exam</b>	\$10 copay
<b>Well-woman exam (includes pap)</b>	\$10 copay; PCP; \$15 copay specialist
<b>Mammogram</b>	100% covered
<b>Pediatric exams</b>	\$10 copay
<b>Immunizations (child)</b>	100% covered
<b>Colorectal screening</b>	100% covered; included in office visit copay
<b>Cancer screenings</b>	100% covered; included in office visit copay
<b>Cardiovascular screenings</b>	100% covered; included in office visit copay
<b>Allergy tests and treatments</b>	100% covered; included in office visit copay
<b>Outpatient Care</b>	
<b>Outpatient surgery</b>	100% covered
<b>Outpatient laboratory services</b>	100% covered; included in office visit copay
<b>Outpatient physical therapy</b>	\$15 copay; limited to 90 visits per calendar year for all therapies combined
<b>Outpatient X-ray</b>	100% covered; included in office visit copay

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<b>Outpatient occupational therapy</b>	\$15 copay; limited to 90 visits per calendar year for all therapies combined
<b>Outpatient speech therapy</b>	\$15 copay; limited to 90 visits per calendar year for all therapies combined
<b>Outpatient cardiac rehabilitation</b>	\$15 copay; limited to 90 visits per calendar year for all therapies combined
<b>Family Planning/Maternity Care</b>	
<b>Office visit: pre/postnatal</b>	\$15 copay initial visit only
<b>In-hospital delivery services</b>	\$100 copay
<b>Newborn nursery services</b>	100% covered
<b>Fertility services</b>	Covered according to New York State guidelines; check with Plan for details
<b>In vitro fertilization</b>	Not covered
<b>Artificial insemination</b>	\$10 copay; PCP; \$15 copay specialist
<b>Female tubal ligation</b>	\$10 copay; PCP; \$15 copay specialist
<b>Male vasectomy</b>	\$10 copay; PCP; \$15 copay specialist
<b>Hearing</b>	
<b>Hearing evaluations</b>	\$15 copay
<b>Hearing aids</b>	Not covered
<b>Vision</b>	
<b>Routine vision exams</b>	\$10 copay; limited to PCP screening; limited to one exam per benefit plan year
<b>Regular lenses and frames</b>	Not covered
<b>Contact lenses</b>	Not covered
<b>Dental</b>	
<b>Dental implants</b>	Not covered
<b>Accidental injury to teeth</b>	Applicable copays apply; must be medically necessary; check with Plan for details
<b>Surgical removal of tumors, cysts and impacted teeth</b>	Applicable copays apply; must be medically necessary; check with Plan for details
<b>Inpatient Services</b>	
<b>Hospital copay</b>	\$100 copay per admission
<b>Hospital semi-private room</b>	100% covered after inpatient hospital copay
<b>Inpatient lab and X-ray</b>	100% covered after inpatient hospital copay
<b>Inpatient surgery</b>	100% covered after inpatient hospital copay
<b>Inpatient physician and surgeon services</b>	100% covered after inpatient hospital copay
<b>Emergency Care</b>	
<b>Emergency room (not followed by admission)</b>	\$50 copay
<b>Urgent care clinic visit</b>	\$10 copay
<b>Ambulance services</b>	100% covered
<b>Prescription Drug Coverage</b>	
<b>Annual prescription deductible</b>	Not applicable
<b>Prescription drug website</b>	Same as medical plan
<b>Prescription drug member services</b>	Same as medical plan
<b>Prescription drug vendor</b>	Same as medical plan

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<b>Annual Rx out-of-pocket maximum</b>	Not applicable
	<b>Retail</b>
<b>Retail generic</b>	\$10 copay; 30 day supply
<b>Retail formulary brand</b>	\$15 copay; 30 day supply
<b>Retail nonformulary brand</b>	\$40 copay; 30 day supply
	<b>Mail Order</b>
<b>Mail order generic</b>	\$5 copay; 30 day supply; three times copay for up to 90 day supply
<b>Mail order formulary brand</b>	\$7.50 copay; 30 day supply; three times copay for up to 90 day supply
<b>Mail order nonformulary brand</b>	\$40 copay; 30 day supply; three times copay for up to 90 day supply
	<b>Other</b>
<b>Oral contraceptives</b>	Retail and mail order available; applicable prescription drug copay applies
<b>Fertility drugs</b>	Covered under New York State mandates; check with Plan for details
<b>Retail injectable drugs</b>	Coverage based on place of service; applicable prescription drug copay or office visit copay applies; check with Plan for details
	<b>Mental Health</b>
<b>Mental Health: Combined with substance abuse</b>	No
<b>Mental Health: Outpatient coverage</b>	100% covered; limited to 60 visits per calendar year; no limit for biologically-based illnesses and children with serious emotional illnesses
<b>Mental Health: Inpatient coverage</b>	\$100 copay; limited to 30 days per calendar year; no limit for biologically-based illnesses and children with serious emotional illnesses
	<b>Substance Abuse</b>
<b>Detox: Outpatient coverage</b>	Not covered
<b>Detox: Inpatient coverage</b>	\$100 copay per admission; limited to seven days per calendar year
<b>Rehab: Outpatient coverage</b>	\$15 copay; limited to 60 visits per calendar year
<b>Rehab: Inpatient coverage</b>	Not covered
	<b>Alternative Care</b>
<b>Chiropractic</b>	\$15 copay
<b>Acupuncture</b>	Covered at a discounted fee when utilizing HIP's network providers; acupressure not covered
	<b>Care Management Programs</b>
<b>Heart disease care management</b>	Yes; congestive heart failure
<b>Hypertension care management</b>	No
<b>Diabetes care management</b>	Yes
<b>Asthma care management</b>	Yes
<b>Prenatal care management</b>	Yes
<b>Cancer care management</b>	No
<b>Smoking cessation program</b>	Yes
<b>Weight control program</b>	No
	<b>Other</b>
<b>Noncustodial home health care</b>	100% covered; limited to 40 visits per calendar year
<b>Hospice care</b>	100% covered; limited to 210 days
<b>Prescribed care in noncustodial skilled nursing facility</b>	100% covered; limited to 90 days per calendar year

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<b>Durable medical equipment</b>	100% covered
<b>Prosthetic devices</b>	100% covered